



University of
Massachusetts
Amherst

A Public Health Initiative to Support the Development of a Trauma Informed Care Culture in a Community Organization that Provides Services to Individuals with Developmental and Intellectual Disabilities

Item Type	Capstone Project
Authors	Coenen, Lisa
DOI	10.7275/14191745
Rights	Attribution-NonCommercial-NoDerivatives 3.0 Unported
Download date	2025-05-14 08:57:44
Item License	http://creativecommons.org/licenses/by-nc-nd/3.0/
Link to Item	https://hdl.handle.net/20.500.14394/37907

A Public Health Initiative to Support the Development of a Trauma Informed Care Culture in a
Community Organization that Provides Services to Individuals with Developmental and
Intellectual Disabilities

Lisa Coenen

University of Massachusetts, Amherst

DNP Project Chair: Dr. Black

DNP Project Mentor: Dr. Margolin

Date of Submission: 03/24/2019

Table of Contents

Abstract.....6

Introduction..... 7

 Quality Improvement 7

 Background.....8

 Problem Statement 13

 Organizational “Gap” Analysis of Project Site..... 13

Review of the Literature 15

 Literature Review Methods..... 16

 Results of the Literature Review..... 17

 Literature Review Discussion 21

 Literature Summary 22

 Project Rationale..... 23

 Evidence Based Practice: Verification of Chosen Option 23

Theoretical Framework..... 24

A PUBLIC HEALTH INITIATIVE TO SUPPORT THE	3
Project Design.....	26
Goals and Objectives	26
Description of the Project Site and Population.....	28
Methods.....	29
Implementation and Project Activities.....	31
Measurement Instruments.....	33
Data Analyses.....	37
Ethical Considerations/Protection of Human Subjects.....	38
Results.....	39
Workgroup Participant Demographic Data	40
ARTIC 10 Scale.....	41
The CCTIC Self-Assessment 1.4 Scale.....	43
The TIC Work Group Participants Feedback Survey.....	46
Discussion.....	50
Knowledge Transference.....	50

Empowerment.....52

Barriers and Facilitators.....53

Cost-Benefit Analysis.....54

Future Recommendations.....55

Project Dissemination.....56

Conclusion 56

References..... 58

Appendices

Appendix A. SAMHSA TIC 4 Rs Conceptual Framework.....72

Appendix B. Trauma Informed Oregon Road Map.....73

Appendix C. CCTIC Self Assessment tool.....74

Appendix D. CCTIC Permission for Tool Use.....86

Appendix E. CT Knowledge Transfer: Foundational Building Blocks” model.....87

Appendix F. Timeline.....88

Appendix G. TIC Work Group Binder (Table of Contents).....89

Appendix H. TIC Work Group Guidelines.....90

Appendix I. Demographic Survey.....91

Appendix J. TIC Work Group Post Project Survey.....95

Appendix K. Informed Consent Form..... 96

Appendix L. Demographic Statistical Data.....101

Appendix M. The ARTIC 10 Scale.....102

Appendix N. Permission to Use the ARTIC 10 Scale.....103

Appendix O. Budget Tables.....104

Abstract

Background: Trauma informed care (TIC) is a socio-ecological theoretical approach for universal practice focus to improve HRQOL and wellbeing outcomes. There is a gap in TIC system implementation for vulnerable populations, including the ID/DD population.

Purpose: The purpose of this project was to transfer knowledge to a newly created TIC work group on the use of an existing TIC system implementation tool to plan, develop, and measure the level of TIC systems culture in their community organization.

Methods: Knowledge transference through the utilization of a TIC systems implementation process map, TIC education, and the facilitation of a TIC assessment and planning tool. Data collection included participant response to online surveys, hard copy survey data, and person-person data collection.

Results and Implications: The work group participants completed the CCTIC TIC Self-Assessment Tool with a significant increase in the presence of TIC organizational culture post project. The ARTIC scale scores for the workgroup participants were more favorable post-project. Upon project completion, the work group participants reported 100 % (N=9) self-confidence in the use of the CCTIC tool to plan, develop, and measure the level of TIC culture in their organization, and the majority of the workgroup recommended the future use of the CCTIC Self-Assessment and Planning Protocol tools to plan, develop, and measure TIC in their organization.

Keywords: CCTIC Self-Assessment Scale, Intellectual / Developmental disability, knowledge transference, health, quality of life, trauma informed care, wellbeing, work group

A Public Health Initiative to Support the Development of a Trauma Informed Care Culture in a
Community Organization that Provides Services to Individuals with Developmental and
Intellectual Disabilities

Introduction

There is a gap in Trauma Informed Care (TIC) systems implementation among community agencies that support vulnerable populations (Gray & Tracey, 2016; Jackson & Waters, 2015; Keesler, 2014a; Keesler & Isham, 2017; Yatchmenoff, Sundborg, & Davis, 2017). This gap lessens the opportunity for vulnerable populations to access a TIC approach to improve their quality of life and avoid harm. The purpose of this piloted quality improvement public health project was to transfer knowledge to an organizational work group on how to use an existing TIC tool to plan, develop, and measure the level of TIC systems culture in their community organization. Through the transference of knowledge on the use of an existing TIC systems tool, work group participants can utilize their new knowledge to mentor and sustain the growth of a TIC organizational systems culture in order to fill gaps in TIC practices in the services provided to the population. With the increase in the quality of the TIC services, opportunities for staff and clients to improve their health-related quality of life (HRQOL) and well-being, and avoid possible harm is anticipated.

Quality Improvement

In the context of quality improvement and health, the U. S. Department of Health and Human Services Health Resources and Services Administration (HRSA, 2011) described quality as “directly linked to an organization’s service delivery approach or underlying systems of care”

(p. 1). Improvement processes are achieved through the input of what and /or how (with more effect with both), which is measurable through “outputs or outcomes” that include “changes in health services” or a “change in health behavior” (HRSA, 2011, p. 2). The two primary inputs for knowledge transference for this project included the what: knowledge transference to a newly formed TIC workgroup within the organization on the use of a formal TIC tool for planning, developing, and measuring TIC culture in an organization (Fallot & Harris, 2009); and the how: the use of explicit and tacit knowledge transference (Caltrans, 2014) of TIC education, resources, and research knowledge.

Background: Trauma Informed Care

Trauma informed care (TIC) is an emerging area of research and research translation practice (Magruder, McLaughlin, & Elmore-Borbon, 2017). The groundwork in developing formal TIC concepts and practice models began through years of research on adverse life events, trauma experiences, and the existing disparities in a person or population’s health, wellness, and quality of life (Federal Partners Committee on Women and Trauma, 2013; Menschner & Maul, 2016; Substance Abuse and Mental Health Services [SAMHSA], 2014a). TIC research continues to be translated by multiple disciplines into TIC practices in quality improvement projects at local, state, national, and international levels (Agency for Healthcare Research and Quality [AHRQ], n.d.; Gray & Tracey, 2016; Peters & Sivistri, 2016). Practice focus for TIC system implementation is commonly directed toward services that support vulnerable populations (SAMHSA, 2014a; United States Department of Justice: National Institute of Corrections, 2017). Target populations for past and current TIC project implementation include, but are not isolated to, children, foster children, children with special needs, women who have suffered abuse,

veterans, and prisoners (Federal Partners Committee on Women and Trauma, 2013; United States Department of Justice:National Institute of Corrections, 2017).

TIC theory. Trauma informed care (TIC) is a social-behavioral intervention, which socio-ecological theoretical underpinnings are designed for the recognition of the influence and the effect of the targeted population's trauma experiences and life adversity, the subsequent risk for trauma stressors and trauma triggering events, and the need for a TIC service delivery approach with the utilization of TIC practice principles to address past trauma (Peters & Sivestri, 2016; SAMHSA, 2014b; Strait & Bolman, 2017). When TIC is systematically built into care services, the recipients of those services and their carers have increased opportunities to experience the benefits from TIC designed environments and TIC focused interactions. This can contribute to a decrease in potentially harmful interactions for all involved parties, both psychologically and physically, and aide in the creation of opportunities to optimize one's health and wellbeing (Bassuk, Latta, Sember, Raja, & Richard, 2017; Marcal & Trifoso, 2017; SAMHSA, 2014b).

The use of SAMHSA's (2014a) TIC practice framework for organizations is a widely accepted TIC organizational conceptual model, which theoretical underpinnings involve four practice assumptions (see Appendix A) identified as the 4 Rs. These 4 R concepts lay the foundation for the implementation of TIC practices, and are operated through a lens to "Realize trauma's impact", to "Recognize the signs and symptoms of trauma", to "Respond" with TIC practices, and to "Resist re-traumatization" (SAMHSA, 2014b, pp.8-10). The focus for TIC service delivery includes five categories of TIC practice principles (also referred to as domains), which include safety, empowerment, trustworthiness, collaboration, and choice (Fallot & Harris, 2009; Keesler & Isham, 2017), although some TIC key-stakeholders have defined, expanded, or

added to these categories (SAMHSA, 2014a). Trauma informed care is not clinical treatment; rather, it is a universal practice approach that can be built into any service delivery (Bartlett et al., 2016; Decandia, Guarino, & Clervil, 2014; Lang, Campbell, Shanley, Crusto, & Connell, 2016; Latham-Hummer, Dollard, Robst, & Armstrong, 2010; Oral et al., 2016).

Among TIC researchers, Fallot and Harris (2009) were part of a group of early pioneers in developing TIC research for TIC research translation practice guidance by embedding TIC assumptions and principles into a TIC operational model that includes the creation of measurable indicators for practice implementation in a systems approach in an organizational setting (Decandia et al., 2014; Federal Partners Committee on Women and Trauma, 2013; SAMHSA, 2014b). This TIC operational model known as the Creating Cultures of Trauma Informed Care (CCTIC) Self-Assessment and Planning Protocol (Fallot & Harris, 2009) is intended for use to plan, develop, and measure the operational level of TIC organizational culture, and is currently validated by TIC leaders for guidance use to build a TIC culture in an organization (Yatchmenoff et al., 2017). Through the facilitation of the CCTIC Organizational Self-Assessment and Planning Protocol (Fallot & Harris, 2009, 1.4 ed), and the support of an expert mentor, organizations can implement a dynamic process toward filling the gaps in TIC service deliveries to vulnerable populations (Trauma Informed Oregon, 2018a; University of South Florida: College of Behavioral & Community Sciences, n.d.; Yatchmenoff et al., 2017).

This project was designed with the theoretical assumptions of the SAMHSA (2014a) 4 Rs TIC organizational framework for organizations, with the use of the CCTIC 1.4 version of Fallot and Harris (2009) TIC self-assessment and planning protocol for organizations. The combination of SAMHSA's (2014a) theoretical TIC guidance and the Fallot and Harris (2009) CCTIC Self-Assessment Tool and Planning Protocol were determined by the DNP student as the best fit for

this quality improvement project to transfer TIC knowledge to a work group on how to plan, develop, and measure the level of TIC culture in the identified organization. The outcome measure for the project was the organization's workgroup participants would report self-confidence in the use of the Fallot and Harris (2009) CCTIC tool to plan, develop, and to measure the level of TIC culture in their organization. The organization's TIC work group outputs on the project were also valuable in identifying their experience in building a TIC culture in their organization to fill identified gaps in TIC service delivery.

ID/DD population and adverse life events and trauma. The population that the partnered organization supports are adults who are diagnosed with an intellectual or developmental disability. An intellectual disability / developmental disability (ID/DD) is loosely defined as an impairment that occurs before the age of 22 which consequence limits cognition and /or function in standard domains (independence, self-care, mobility, language, learning, and economic independence) (Institute on Community Integration: ICI, 2017; Krahn & Fox, 2014). There are approximately 5 million people living in the United States with an intellectual or developmental disability (United Healthcare, 2016).

Trauma and abuse. The ID/DD population are a vulnerable population who have a higher reliance on community agency services, have a history of poor HRQOL and wellbeing outcomes, and are identified to have a higher incidence of trauma than the general population (Florida Developmental Disabilities Council, 2009; Wigham & Emerson, 2015). Annual incidences of abuse among the ID/DD population are estimated to be 4-10 times more likely than the standard population (Disability Justice, 2017). The incidence and prevalence of trauma reported among the ID/DD population include Marcal and Trifoso's (2017) literature review

findings that detailed a higher incidence of neglect, physical abuse, and sexual abuse among children with disabilities in a school record review in Omaha (citing Sullivan & Knutson, 2000), a higher prevalence of abuse among adults with disabilities (citing Horner-Johnson & Drum, 2006). Girls with disabilities were twice as likely to be raped (citing National Youth Risk Behavior Survey, 2005). In addition, sexual abuse is under reported in the ID/DD population with estimates as low as 1 in 30 cases compared to the general population, which is estimated as 1 in 5 as sexual abuse cases, and the ID/DD population suffer higher rates of adverse life events (Tallant, n.d.,slide 3-4).

Health related quality of life and wellbeing. In regard to health outcomes, United Health Care estimated that more than 50% of people with ID/DD have multiple chronic health conditions (2016). Among the ID/DD population, Hulbert-Williams et al., (2014) hierarchal regression analyses found that adverse life events (which included transient care givers, illness, hospitalizations, abuse, violence, and restraints) were also associated with various psychological stressors; though sample size and bias were considered in study findings. In a comprehensive literature review, Bigby and Beadle-Brown (2016) addressed the prevalence of the poor quality of life (QOL) outcomes in the ID/DD population and the existing research on services that enhanced QOL through multiple propositions, which included supporting evidence for organizational supports that are “coherent, enabling, motivating and respectful... [and provide] strong organizational policies and practice in the area of HR”, with a built in cultural approach (p.12). The authors concluded that the services through a QOL lens for individuals with ID/DD is understudied, and emphasized the need to fill the gap in knowledge of the integration of QOL service propositions into new theoretical QOL supports within designated settings, which includes the strongest evidence in propositions such as leadership focus, managerial

commitment, and staff engagement (Bigby & Beadle-Brown, 2016, p.13). In regard to study recommendations on QOL and the ID/DD population, Tomlinson et al's. (2014) list of research priorities includes the need to expand public health research focus to improve the health and wellbeing outcomes among the ID population. The world view of TIC and its operational assumptions are grounded in the theory that the implementation of TIC in an organization can create an environment that improves HRQOL and well-being outcomes through the quality of TIC interactions between support agents and service populations (to include ID/DD), which opportunities increase with the dosing and frequency of these positive experiences during service delivery to benefit both the staff and the client (Brown, Baker, & Wilcox, 2012; Gray & Tracey, 2016; Keesler, 2014a; SAMHSA, 2014a).

Problem Statement

Individuals with ID/DD are at risk for re-traumatization, traumatic stress, trauma triggering events, poor health related quality of life and wellbeing outcomes when community support agencies and their direct support staff do not implement trauma informed care practices grounded in a systematic trauma informed care service delivery.

Organizational “Gap” Analysis of Project Site

There is a practice gap in the system implementation of trauma informed care (TIC) among community organizations that provide supports to vulnerable populations, which includes individuals with ID/DD (Gray & Tracey, 2016; Jackson & Waters, 2015; Keesler, 2014a; Keesler & Isham, 2017; Yatchmenoff et al., 2017). This gap lessens the opportunity for vulnerable populations (including individuals with ID/DD) to access environments and services

that are embedded in a TIC organizational model that includes service deliveries that promote empowerment, choice, safety, trust, and collaboration, which can influence one's quality of life in health and well-being outcomes (Fallot & Harris, 2009; Jackson & Waters, 2015; Keesler & Isham, 2017; SAMHSA, 2014a; Wigham & Emerson, 2015). The 4Rs TIC concept model (SAMHSA, 2014b) for building an organizational culture, with the Fallot and Harris' (2009) CCTIC Self- Assessment and Planning Protocol tools, are a good fit for TIC systems implementation for organizations that support the ID/DD population due to the population's high incidence and prevalence of trauma, and the need for informed service delivery that recognizes their trauma past, and the need to implement TIC practices to protect individuals with ID/DD from incurring unnecessary future trauma (Gray & Tracey, 2016; Keesler & Isham, 2017; Marcal & Trifoso, 2017).

Barriers in creating a TIC organizational culture. In addition to the practice gap in TIC practices in community organizations that support vulnerable populations, barriers to the successful development of a TIC organization include staff attitudes and beliefs about utilizing TIC principles (Baker & Brown, 2016). The measurement of staff 's TIC attitudes and beliefs (often pre-post TIC education) can aide the educator and the organization in identifying strengths and weakness' in an organization's TIC service delivery (Baker & Brown, 2016; Fallot & Harris, 2009)). The measurement of staff attitudes and beliefs pre-post TIC education was built into this project to help support the organization in TIC systems planning and development.

Description of community organization's service population. Layers of socio-economic determinants exist in the complexities of the progress made in the prevention, treatment, and care of individuals with ID/DD, and family supports, which includes poverty,

stigma, bias, access to healthcare, cultural beliefs, a lack of political will, a lack in housing, a lack of quality direct care providers, and segregated practices (Hulbert-Williams et al., 2014; John F. Kennedy Presidential Library & Museum, 2017; Wigham & Emerson, 2015; Wigham, Hatton, & Taylor, 2011). In 1963, the tide of services changed when the “Maternal and Child Health and Mental Retardation Planning Amendment to the Social Security Act” was enacted as the first major legislation to combat mental illness and intellectual disabilities” (John F. Kennedy Presidential Library & Museum, 2017, section: Legislation for Mental Health Care). This legislation, with the addition of multiple lawsuits, and community advocacy led to the movement of community based supports for individuals with ID/DD, and the passing in the 1970s of the federal legislation “Developmental Disabilities Assistance and Bill of Rights Act of 1975”, which required states to create formal systems for improved quality of the services and care provided for individuals with ID/DD (Protection & Advocacy for People with Disabilities, 2017). Individuals with ID/DD are a vulnerable population who benefit from the pro-active supports from policy makers, community advocates, funded agency supports, and public health programs to ensure that this population can achieve optimal health and well-being outcomes (Carroll-Chapman & Wu, 2012; Keesler, 2014a; Special Olympics, 2009). TIC promotes the well-being of individuals, and it is a positive intervention for better health outcomes (SAMHSA-HRSA, 2015). Currently, there are over 200 agencies who provide services to the ID/DD population in the state of Massachusetts. These agencies are currently not required to participate in TIC education or to identify as TIC organizations, although TIC education is available through the state’s website (Commonwealth of Massachusetts, 2017).

Review of the Literature

The intention of the DNP student's literature review was to gain a deeper understanding of TIC implementation among community organizations that support vulnerable populations, to identify the barriers to TIC implementation and the gaps and inconsistencies in TIC practice, and to review study recommendations for TIC implementation in an organizational setting. This literature review aligns with the purposes designated under the United Nations' guidance for the rights for populations with disabilities, which promotes the responsibility of key stakeholders to perform research and to disseminate research findings with a focus to improve the health and wellbeing of individuals with disabilities (Gray & Tracey, 2016; United Nations, 2006).

Literature Review Methods

The literature search was performed utilizing the academic databases of PUB-MED, Premier, ProQuest, the Cumulative Index to Nursing and Allied Health Literature (CINAHL), EBSCO, Google Scholar, Mendeley, the Institute for Community Inclusion database, Wiley and Springer journal subscription services, and Elsevier. Initial search terms included "intellectual disability" with "trauma informed care" with "assessments", which produced over 24,000 results on EBSCO alone. A modified search on EBSCO to "trauma informed care for intellectual disabilities" plus "assessments" produced 526,000 results. From this process, the term "assessments" was excluded. A new search was initiated through UMASS Amherst library utilizing academic data bases with the search terms "trauma informed care" and "disabilities". The search mode included "Boolean /phrase", and to "find all search terms".

The inclusion criteria for publications were "science journals", "English language", "peer reviewed", dated from "2010", which produced 46 results, of which 20 articles were saved for further review. From that search, this author modified the search terms on the search engines

mentioned to “trauma informed care frameworks for intellectual disabilities” with inclusion for “English language”, “peer reviewed”, “full text”, “electronic”, dated from “2010”. From the multiple searches, 35 articles were added to the DNP student’s literature database for review.

A further defined search on PUB-Med with the search term “trauma informed care framework” with inclusion filters: “free full text”, “full text”, “published in the last 10 years”, and “humans” yielded 15 results with one relevant article result. Then, using the same filters with the search terms “trauma informed care”, and “staff education” with Pub Med Mesh terms for “wounds”, “injuries”, “care”, “staff”, and “education” subheading or “educational status” yielded 44 study results for review. Another Pub-med user inquiry for terms “ACE study”, “trauma informed care”, “education” yielded one article, which was relevant to this review. An EBSCO-host CINAHL data base search with search terms based on “smart search” from previous searches yielded terms for “children's coping with family violence”, “policy and service recommendations”, “coping in infancy and childhood domestic violence support”, “psychosocial hardiness child: 6-12 years”, and “trauma informed care” yielded 46 results. Of these results, the author found 11 relevant articles for review. The following literature review was performed through the accumulation of a TIC literature data bank using an exploratory literature review method for TIC topic relevance, and a systematic review of the determined relevant literature for research review synthesis.

Results of the Literature Review

The literature reviewed included the following sectors: one state run child welfare agency (Lang et al., 2016), one statewide initiative (Bartlett et al., 2016), two child psychiatric settings (Azeem et al., 2015; Latham-Hummer et al., 2010), one academic setting for medical students

(Strait & Bolman, 2017), one national initiative to improve TIC guidelines (Bassuk et al., 2017), four research studies (national and international) with a focus on services for individuals with ID/DD (Berg, Shiu, Acharya, Stolbach, & Msall, 2016; Gray & Tracey, 2016; Keesler, 2014b; Keesler & Isham, 2017), and one research sector for a TIC brief on TIC implementation across sector settings (Decandia et al., 2014).

The literature review research findings of TIC education and utilization were predominantly reviews of literature and qualitative research studies, which study methods were performed through interviews, care provider assessment scales, case studies, historical records, and data tracking measures (Azeem et al., 2015; Bartlett et al., 2016; Berg et al., 2016; Gray & Tracey, 2016; Latham-Hummer et al., 2010; Keesler & Isham, 2017; Keesler, 2014b; Lounds Taylor & Gotham, 2016; Salinas-Miranda et al., 2015; Strait & Bolman, 2017). Additional literature included Decandia et al.'s (2014) brief on TIC implementation guidance across service sectors, Yatchmenoff et al.'s (2017) review of how to successfully implement TIC in an organization, and Bassuk et al.'s (2017) 2 step Delphi study to modify existing TIC guidelines for universal design in health care settings through the utilization of an expert panel for TIC guideline review and revision, and a feedback survey for rating the revised guidelines for practice use.

The primary theme identified for TIC implementation in an organizational setting is the intention to optimize an environment where vulnerable populations can increase the opportunity for positive experiences, and decrease the risk of re-traumatization to contribute to the ability to improve one's quality of life and wellbeing in HR-QOL domains (Azeem et al., 2015; Bartlett et al., 2016; Bassuk et al., 2017; Healthy People 2020, 2017; Latham-Hummer et al., 2010; Keesler, 2014b; Lang et al., 2016; Oral et al., 2016; Strait & Bolman, 2017; Wigham & Emerson, 2015).

For TIC quality improvement, the reviewed literature was lacking in the use of a TIC framework in study designs with the exception of Azeem et al., (2015), Gray and Tracey (2016), and Lang, Campbell, Shanley, Crusto, & Connell (2016) studies. Lang et al.'s (2016) study use of a TIC framework and an education framework for TIC implementation in a state organization was comprehensive, with one year of planning, and 4 years for study implementation and evaluation. Gray and Tracey (2016) also utilized EB strategies from a TIC framework for assessing TIC readiness among staff and for TIC implementation. Latham-Hummer et al.'s (2010) case study research findings of inconsistent TIC organizational practices led to the researchers' creation of a new TIC framework.

Significant data findings were delineated in some studies which included Lang, et al.'s (2016) initial gain in TIC implementation and in differences in organizational readiness and capacity for TIC that increased from year 1 to year 3 in the TIC domains areas in direct support staff training and education ($p < .001$), in access to trauma supervision and supports ($p < .001$), and in trauma related supports for families ($p < .001$). Strait and Bolman (2017) reported increased knowledge of TIC practices ($p < .02$) and adverse childhood experience research findings after self ACE assessments were performed ($p < .001$). The lack of rigor in data evaluation did not preclude the value in Azeem et al.'s study findings that noted a complete elimination for mechanical restraints, and an 88% reduction in physical restraints (from 3,033 to 379) in a psychiatric hospital for children over a 10-year period through the implementation of TIC principles, and strength-based care.

The authors, Bassuk et al.'s (2017), study added value to future TIC implementation in health care settings for underserved populations through the comprehensive review and evaluation of current TIC practice guidelines for universal design implementation, and to address

practitioner's ignorance and negative attitudes related to trauma and the mental health challenges and disease conditions associated with its long-term effects on health and wellbeing. Study limitations included small sample sizes, lack of respondent participation and staff turnover, and a lack of outcome measurement tools for TIC implementation outcomes (Bartlett et al., 2016; Bassuk et al., 2017; Decandia et al., 2014; Lang et al., 2016; Latham-Hummer et al., 2010).

Trauma informed care outcomes. There are several health-related quality of life and wellbeing outcomes that can be optimized when TIC is operated in services and supports for individuals. (Bassuk et al., 2017; Keesler, 2014a). The Center for Substance Abuse Treatment (2014) delineated the health and wellbeing areas impacted by trauma to include all aspects of one's physical, psycho-social, and behavioral development, which negative health and wellbeing outcomes include adverse emotional reactions and shame, psychological responses of mood alterations and mental status changes, physiological states of the fight-flight-freeze response, and adverse health conditions that include sleep disturbances-autoimmune disorders-elevated cortisol levels, and unstable social interactions including mal-adaptive behaviors (section: Exhibit 1.3-1: Immediate and Delayed Reactions to Trauma). TIC is also attributed to the decrease in trauma triggering stressors that can aid in the reduction of consequential interventions (including restraints) to these reactions (SAMHSA, 2014b).

The outcome focus of TIC implementation is to avoid causing harm during service delivery and in direct interactions, and to increase one's opportunity to improve their HRQOL and wellbeing outcomes (Decandia et al., 2014; Gray & Tracey, 2016; SAMHSA, 2014b). In Azeem's (2015) study, the introduction of TIC and positive behavior supports led to a reduction in the use of medical, physical, and mechanical restraints which had contributed to an increased risk in harm and adverse health outcomes for staff and restrained individuals. According to

Healthy People 2020 (2010) Health related quality of life is represented in the physical, psychological, and social domains and includes one's ability to function and their wellbeing (p.1). Addressing the gap in TIC practices among vulnerable populations is a growing area of public health practice focus, especially in organizational approaches among vulnerable populations (Peters & Silvestri, 2016), and is gaining ground in national legislation (Purtle & Lewis, 2017).

Literature Review: Discussion

The quality of evidence was reviewed based on the John Hopkins Rating Scale (Newhouse, Dearholt, Poe, Pugh, & White, 2005) The quality of the literature reviewed is believable, and demonstrates a high expertise of TIC theory with robust delineations of study intentions and study method descriptions, and the inclusion of TIC literature reviews. The nature of qualitative data collection led to the author's findings of a lack in study rigor in a majority of the data evaluation (Coughlan, Cronin, & Ryan, 2007).

A lack of TIC systems implementation was identified as a contributing factor or challenge in sustaining organizational TIC practices (Bartlett et al., 2016; Bassuk et al., 2017; Decandia et al., 2014; Lang et al., 2016; Latham-Hummer et al., 2010; Strait & Bolman, 2017). In addition, other challenges to sustaining TIC implementation and culture included a lack of organizational commitment to TIC implementation (Bassuk et al., 2017; Latham-Hummer et al., 2010; Strait & Bolman, 2017), a lack of organizational resources, and a lack of staff access to TIC expertise (Azeem et al., 2015; Bartlett et al., 2016; Bassuk et al., 2017; Decandia et al., 2014; Keesler & Isham, 2017; Lang et al., 2016; Latham-Hummer et al., 2010; Strait & Bolman, 2017). In the majority of the literature reviewed, the use of universal TIC assumptions and

principles were operationalized at some level (Bartlett et al., 2016; Bassuk et al., 2017; Lang et al., 2016; Latham-Hummer et al., 2010). In addition to TIC research study focus, study intentions from TIC systems implementation aligned with TIC propositions to optimize an environment where vulnerable populations can increase the opportunity for positive experiences, and decrease the risk of re-traumatization, which outcomes contribute to the ability to improve one's health related quality of life and wellbeing (Azeem et al., 2015; Bartlett et al., 2016; Bassuk, Latta, Sember, Raja, & Richard, 2017; Healthy People 2020, 2017; Hummer, Dollard, Robst, & Armstrong, 2010; Keesler, 2014; Lang et al., 2016; Oral et al., 2016; Strait & Bolman, 2017; Wigham & Emerson, 2015).

Literature Review Summary

The review of the literature identified study implementation challenges and barriers in introducing TIC into an organization and factors that influence positive or negative perceptions of system implementation of TIC practices. Existing gaps in TIC implementation in organizations and knowledge about the current challenges in the lack of measurement tools for outcome evaluation of TIC implementation were also explored (Bartlett et al., 2016; Decandia et al., 2014; Latham-Hummer et al., 2010; Oral et al., 2016; Strait & Bolman, 2017).

Overall, research literature on TIC implementation focus aligned with the philosophical underpinnings to acknowledge trauma and adverse life events in the target population, to provide trauma informed practice interventions as a response to trauma acknowledgment, and to create opportunities to optimize health related quality of life and wellbeing (Bassuk et al., 2017; Gray & Tracey, 2016; Keesler & Isham, 2017).

There is an abundance of existing literature on the implementation of trauma informed care, which is steadily building among a broader array of community organizations that support vulnerable populations, including a new direction among providers who support individuals with intellectual and developmental disabilities (Gray & Tracey, 2016; Marcal & Trifoso, 2017). For project design, key information was obtained from TIC study findings and study recommendations to include methods for feedback from staff and policy makers in the TIC systems implementation process in order to define TIC implementation weakness', to fill gaps in supports, and to sustain TIC culture and practices (Azeem et al., 2015; Bartlett et al., 2016; Keesler & Isham, 2017; Lang et al., 2016; Latham-Hummer et al., 2010).

Project Rationale

The priority in the project design included the findings from the review of literature where TIC is most effective in systems implementation (Bartlett et al., 2016; Bassuk et al., 2017; Lang et al., 2016; Latham-Hummer et al., 2010). Recommendations from previous TIC studies and TIC systems implementation approach include the need to fill gaps in structural and staff supports, to provide access to TIC expertise, to implement a systematic approach for building a TIC organization, and to include staff in TIC organizational implementation process' (Azeem et al., 2015; Bartlett et al., 2016; Bassuk et al., 2017; Decandia et al., 2014; Lang et al., 2016; Latham-Hummer et al., 2010; Strait & Bolman, 2017). A primary theme identified for TIC implementation was the need for government and lead organization agents (top administration) to prioritize TIC into their targeted population service deliveries (Decandia et al., 2014; Latham-Hummer et al., 2010).

Evidence Based Practice: Verification of Chosen Option

The purpose of this quality improvement project was to transfer knowledge to an organizational work group on how to plan, develop, and measure the level of trauma informed care culture through a systems approach in their organization. With the transference of new knowledge through project activities, the TIC work group were provided with an opportunity to learn new skills on how to identify and fill gaps in their organization's TIC practice culture in a system's approach. Evidence based TIC theory was embedded in the project design through the use of the SAMHSA (2014a) TIC 4 Rs organizational conceptual model, and taught in the DNP student's TIC education to the workgroup, and utilized for the theoretical guidance for the TIC work group activities (See Appendix A). The content for TIC education for the work group participants included the SAMHSA (2015) education materials, which are available for public use without the necessity to obtain consent. For a guiding framework for project implementation, the SAMHSA (2014a) 4 R assumptions were reviewed during work group activities, which concepts are embedded in the Fallot and Harris (2009) CCTIC Planning and Protocol tools, and the Trauma Informed Oregon (2018a) TIC Roadmap process map (See Appendix B).

The Fallot and Harris (2009) CCTIC Self-Assessment and Planning Protocol (See Scale in Appendix C) is used by diverse organizations that support vulnerable populations (Yatchmenoff et al., 2017) to provide a formal system for an organization to plan, develop, and measure the operation of TIC practice principles in an organization (Fallot & Harris, 2009). The Fallot and Harris (2009) CCTIC tools are appropriate for work group use (Fallot & Harris, 2009). The Fallot and Harris' (2009) CCTIC self-assessment scale and planning tool is available for use with the author's permission, which use was granted for this project (see Appendix D).

Theoretical Framework

To evaluate evidence for use in a quality improvement project, one must weigh the internal consistency of research findings, and identify that the body of research is grounded in a practice model that is appropriate for implementation among the targeted population (Shojania, McDonald, Wachter, Owens, & Markowitz, 2004, p.18). Public health key-stakeholders have begun to fill the gap in study outcome findings on what HRQOL and well-being outcomes can be achieved through TIC practice implementation among populations who are vulnerable, including populations that have an inequitable distribution of trauma events, and adverse life experiences (Gray & Tracey, 2016b; Clinic Community Health Centre, 2013; Magruder, Kassam-Adams, Thoresen, & Olf, 2016; SAMHSA-HRSA, 2015; Wisconsin's Violence Against Women with Disabilities and Deaf Women Project, Disability Rights Wisconsin, Wisconsin Coalition Against Domestic Violence, & Wisconsin Coalition Against Sexual Assault, 2011). When building TIC into an organizational culture for a systems approach, the SAMHSA (2015) 4 Rs TIC model contains the foundational theoretical underpinnings that are universal to any area of service delivery. Additionally, the 4 Rs TIC assumptions are operational at any level of an organization for TIC systems implementation (SAMHSA, 2014a). The Fallo and Harris' CCTIC self-assessment and planning protocol (2009) has these general concepts embedded into the operational model, with additional practice focus, which consists of 5 TIC operational principles: "safety", trustworthiness, "choice, "collaboration, and "empowerment", and 6 categorical measurement domains for measuring an organization's level of TIC culture (pp. 1-2). The TIC 4 R assumptions from SAMHSA (2014a) theoretical model combined with the Fallo and Harris' (2009) CCTIC tool use (for organizations to plan, develop, and measure TIC culture in their organization) provided the conceptual and operational TIC models to meet the project goal.

The SAMHSA (2015) 4 Rs conceptual model and the Fallot and Harris (2009) CCTIC systems model were applicable for operation in this quality improvement project due to their design for universal use, their research roots in rigorous systematic literature reviews and expert guidance, the allowance for design modifications for site specific implementation, and the anticipation of reciprocal benefits when implemented (SAMHSA, 2014a; Yatchmenoff et al., 2017). With the mixed use of SAMHSA (2015) TIC assumptions model, and Fallot and Harris' (2009) CCTIC Self-Assessment and Planning Model with research translation and knowledge transference methods, this author implemented a TIC quality improvement project with a designated organizational workgroup on how to plan, develop, and measure the level of TIC culture in their organization.

Project Design

This project was designed for work group activities that involved TIC education, DNP student mentorship, and active work group participation. Project steps aligned with the Roadmap for Trauma Informed Care, which is a process model for organizations to follow when introducing TIC to an organization, and for sustaining a TIC culture (Trauma Informed Oregon, 2018b). The project activities occurred over an 8-month period from August, 2018- February, 2019. The evaluation phase of the project ended in March, 2019 with the DNP student's completion of data collection, evaluation, and project synthesis. Dissemination of the project findings were approved by the work group participants and the Assistant Chief Operating Officer (ACOO) from the organization.

Goals and Objectives

The primary goal of this quality improvement project was to transfer knowledge to the TIC workgroup participants on the use of a formal tool for TIC systems planning, for TIC organizational development, and for the measurement of the level of TIC culture in an organization that provides services to individuals with ID/DD (See Figure 1 for knowledge transference process). The project objectives were accomplished through the utilization of a mixed use of explicit and tacit knowledge transference methodology, where explicit knowledge transference occurred through TIC education, and the facilitation of the Fallot and Harris' (2009) CCTIC tool use by the workgroup, and through the DNP student mentoring tacit TIC knowledge transference during workgroup processes (Caltrans, 2014, p. 3). This mixed method approach was facilitated by the DNP student with the work group participants utilization of the process step guidance delineated in the Trauma Informed Oregon, (2018a) Roadmap process steps. These steps and the accompanying resources are available for public use and download from the Trauma Informed Oregon (2018) website.

To implement the project goal, the first step was to ensure the work group participants had the opportunity to receive formal TIC education, which was provided by the DNP student during the Readiness Phase in September, 2018. The Implementation phase consisted of work process steps that included mentorship of the TIC workgroup monthly (or bi-monthly) meetings, and the TIC work group participants facilitation of Fallot and Harris' (2009) CCTIC organizational self- assessment and planning tool during both the Readiness and Implementation phases of the project.

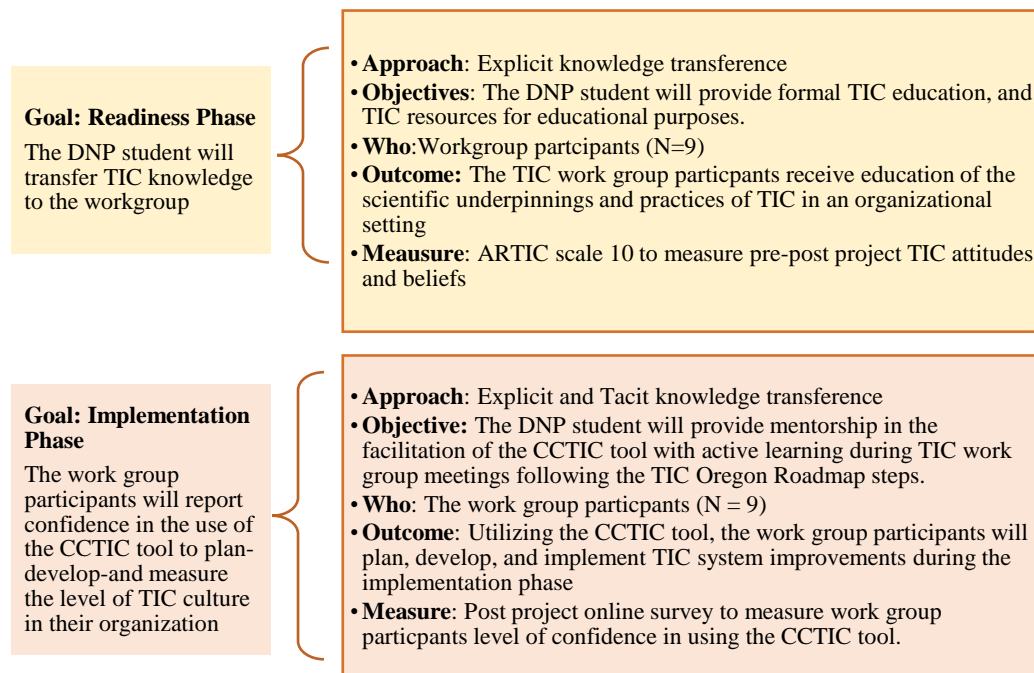


Figure 1. Knowledge Transference: Goals, Objectives, and Outcomes. Note. Goal 1 (Explicit Knowledge Transference), and Goal 2 (Tacit Knowledge Transference).

The outcome measurement of this quality improvement project was the workgroup participants’ responses to an online survey of their reported level of confidence in the use of a TIC tool to plan, develop, and measure TIC culture in their organization. The project outcomes measurement data was collected by an online survey after the workgroup participants demonstrated the use of the Fallot and Harris’ (2009) CCTIC self-assessment and planning tools: which occurred at the beginning of the Readiness phase, and repeated implementation at the end of the project’s Implementation phase. The outcome measurement survey was disseminated to the work group participants for the identification of their level of self- confidence in the use of the CCTIC tools.

Description of the Project Site and Population

The project site was a community organization that supports approximately 600 individuals, who are identified for need of community supports from multiple cities in the state. The organization offers direct services (residential, day programs, vocational, and community) to adults who have an ID/DD diagnosis, and various other services to the families of the individuals they support. The partnered organization's Assistant Chief Operating Officer (ACOO) reviewed and approved the DNP student's project proposal and timeline during project planning, and agreed to the organizational resources needed for project implementation. These resources included onsite meeting space, designated time for staff training, designated meeting schedules, and project collaboration with the newly created TIC workgroup participants.

Methods

Project implementation began with the first TIC work group meeting in August, 2018. The methods for the project implementation included the DNP student's provision of TIC education to the workgroup, mentorship of the utilization of the Trauma Informed Oregon Roadmap process steps and resources (Trauma Informed Oregon, 2018, see Appendix B), and mentorship of the workgroup's facilitation of the Fallot and Harris (2009) CCTIC self-assessment and planning protocol (see Appendix C).

The TIC workgroup. The TIC workgroup (N = 9) was created through an internal organizational process during the spring-summer of 2018. The partnering organization's ACOO invited organizational staff for TIC workgroup participation. Work group participant representation included a representative from Human Resources, the ACOO, management staff, direct care staff, and clinicians. The TIC work group participants were identified as staff who volunteered to join the work group based on their interest in learning more about trauma

informed care. The DNP student did not participate in any activities involving the formulation of the organization's TIC workgroup, nor had any influence in how the organization determined the final TIC work group participants. The main activity was in the provision of support to the identified TIC workgroup participants in gaining knowledge on how to plan, develop, and measure TIC in their organization.

The TIC workgroup participants determined the meeting schedule (monthly) and additional meeting agendas. Workgroup flexibility for TIC workgroup activities was intentionally built into this project to increase productivity, and the likelihood of better success in project outcomes (Issel & Wells, 2018, p.170). TIC system implementation is most effective through the creation of a workgroup with a focus on organizational assessment, TIC systems planning, monitoring TIC system changes, and modifying existing practices (Trauma Informed Oregon, 2018a; Yatchmenoff et al., 2017). This project was designed to include these TIC workgroup dynamics through the implementation of the specified TIC workgroup activities that occurred during the TIC work group meetings.

Knowledge transference. For quality improvement project implementation, the transference of knowledge effect is increased in activities that promote audience engagement (Lavis et al., 2003). Knowledge transference can lead to a dynamic process when the information is delivered in a manner that promotes a reciprocal relationship between the party transferring knowledge and the targeted party receiving it, to the end that both parties participate and gain new knowledge (Reardon , Lavis , & Gibson , 2006). When targeting an audience for knowledge transference, the knowledge broker's consideration of the influence of the audience (i.e. leadership, management) in the use of knowledge is key in how knowledge will influence practice (Lavis et al., 2003). Knowledge transference is often utilized in public health projects

for education, and is based on outcomes or process measurement, and is most effective when tailored to the targeted population, with tools that have reliable test-retest measurability (Siron, Dagenais, & Ridde, 2015).

Implementation & Project Activities

The project proceeded according to the project timeline (See Appendix F). Each meeting involved a review of the Road Map for TIC Readiness plan and procedural steps (Trauma Informed Oregon, 2018b) with the accompanying model resources from the website. The Trauma Informed Oregon (2018b) resources were provided in a binder to each work group participant (see Appendix G for Table of Contents), and included the Trauma Informed Oregon (2016) work group guidelines (see Appendix H). During work group meetings, the participants determined other agenda items, and a time for questions, answers, and concerns was allotted at each TIC workgroup meeting. Work group activity outputs are described below:

The Readiness Phase activities:

- Project introduction which included a review of the informed consent for voluntary participation and a confidentiality protection disclosure (August, 2018, first meeting).
- The facilitation of a work group participant communication plan and TIC work group self-care plan with the workgroup participants (August, 2018).
- The review of the Trauma Informed Oregon (2018) TIC work group guidelines with the TIC work group participants (August, 2018).
- An online demographic survey (see Appendix I) was sent to the TIC workgroup participants through Survey Monkey, which data was collected anonymously,

with only the email group information available for survey distribution (September, 2018).

- The TIC workgroup completed the Artic 10 scale (September, 2018).
- The DNP student presented a three-hour TIC education in-service to the TIC workgroup with the use of SAMHSA's (2015) TIC power point and the National Center for Trauma Informed Care (2015) companion instructor's guide (September, 2018).
- The DNP student provided each of the TIC work group participants a TIC resource binder that contained the TIC Road Map materials (Trauma Informed Oregon, 2018), the Fallot and Harris (2009) CCTIC tools, and miscellaneous TIC materials (September, 2018).

The Implementation Phase activities

- The introduction of the Fallot and Harris (2009) CCTIC tool, and the TIC workgroup experiential use of the tool to score the level of TIC culture in the organization (October, 2018). The workgroup participants identified and scored the current level of TIC organizational culture in the CCTIC Domain subscales and an overall TIC culture score
- The CCTIC domain and over all scores were collected, evaluated by the DNP student and disseminated to the work group by email, and in hard copy.
- The TIC workgroup participants identified, from the Fallot and Harris (2009) CCTIC tool, indicator gaps from the 6 domains to develop during the implementation phase of the project (October, 2018- February, 2019).

- The workgroup participants decided to meet weekly to continue their work on implementing their organizational goals from the identified gaps from each domain on the scored CCTIC tool. (November, 2018 - February, 2019).
- The work group participants planned and implemented a trauma informed care kickoff event for 275 employees (February, 2019).
- The work group participants repeated use of the Fallot and Harris (2009) CCTIC tools, and the TIC workgroup scored the new level of TIC in the organization (February, 2019).
- The DNP student collected the work group participants' second completion of the ARTIC 10 scale (Baker & Brown, 2016), (February, 2019).
- An online survey (through Survey Monkey) was distributed to the TIC work group participants to elicit feedback on the TIC workgroup participants' level of confidence in planning, developing, and measuring TIC culture in their organization using the Fallot and Harris (2009) CCTIC tool, and whether the participants recommended the tool for future organizational use for the aforementioned purposes (March, 2019).

Measurement Instruments

Demographic data collection for the work group participants including inquiry of their work role, their gender, their level of education, their number of years working with the agency, and whether the participant had previous trauma informed care training. The demographic data was collected through a Survey Monkey process, and sent to the work group participants through

an anonymous online response method with an introduction explanation that the survey was voluntary.

CCTIC Self-Assessment tool. The tool utilized for the TIC work participants to measure the level of TIC organizational culture in their organization was the Fallot & Harris (2009) CCTIC 1.4 self- assessment and planning protocol. The Fallot and Harris (2009) CCTIC self -assessment and planning protocol tool is accepted by the key stakeholder community for developing, planning, and measuring a TIC culture in an organization (The Trauma Informed Care Project, 2017; Yatchmenoff et al., 2017). Included in this tool, is the Fallot and Harris (2009) CCTIC scale, which is designed to be completed by an appointed work group in an organization to score the level of TIC culture for quality improvement in TIC service delivery (Fallot & Harris, 2009). The Fallot and Harris (2009) CCTIC tool is used as a guide to aid organizations in filling gaps in TIC practices within the organization, and has test-retest utility to meet test stability criteria (Perrin, 2016). Workgroup dynamics for test-retest reliability were documented to include the number of participants involved in completing the tool (N=9), the time for task completion (2 hours), and the proportion of the tool elements in the form that were completed (6 domains). The Fallot and Harris (2009) tool is not for scientific measurement for quantitative study rigor, but for a dynamic work process tool to guide the organization in a continuous self-assessment of the organizational presence of TIC model assumptions, and the TIC operational principles operated in service delivery. The use of the Fallot and Harris (2009) CCTIC self- assessment and planning protocol tool for an organization is to create and strengthen a TIC culture in the organization for improved service delivery (Fallot & Harris, 2009).

ARTIC 10 scale. To measure the differences in the TIC work group participants TIC attitudes and beliefs, the ARTIC 10 scale was administered during the Readiness and Implementation phases of the project. The Artic Scale (Baker & Brown, 2016) is utilized for organizations that have not introduced TIC education to an organization, and it was specifically designed to fill the gap in trauma informed care instruments to measure categorical TIC attitudes and beliefs in the work setting (Baker, Brown, Wilcox, Overstreet, & Arora, 2015). The ARTIC scales were developed through a CBPR initiative, are peer reviewed, the reported internal consistency is high ($\alpha = .82$), and the data findings can be analyzed with the use of statistical software or with Excel (Baker et al., 2015). Among the ARTIC scales, the ARTIC 10 scale data can be evaluated using descriptive statistical analysis to find the mean differences (sub-scale items and total score) in test-retest scores, and includes scale instructions for recoding the scale items (Baker & Brown, 2016). The information from the completed Artic 10 scales can provide concrete data of the changes in a workplace's TIC attitudes and beliefs pre-post TIC education and training (Baker & Brown, 2016).

TIC work group participants survey. The outcome measurement of this quality improvement project included the workgroup participants' responses to an online survey (see Appendix J) of their level of confidence in the use of a TIC tool to plan, develop, and measure TIC culture in their organization. The online survey was distributed to the work group participants after the workgroup participants completion (DNP student observation) of the use of the Falloot and Harris' (2014) CCTIC self-assessment and planning tools at the end of the project's implementation phase (February, 2019). The TIC work group participant survey was sent to the TIC work group participants through SurveyMonkey (2018), which contained two questions and a comment box (see Appendix J). The questions were designed to measure the

TIC workgroup participants' feedback on 1. Their perception of their level of confidence in using the Fallot and Harris CCTIC tools to plan, develop, and measure the level of TIC culture in their organization, and 2. Whether they would recommend the continued use of the Fallot and Harris (2009) CCTIC tool to plan, develop, and measure the level of TIC culture in their organization. The survey responses were collected through an anonymous online response method through the survey monkey (2018) website, and were evaluated for percentages of respondent answers in the identified categories.

Knowledge transference. The guiding framework (see Appendix E) for transferring knowledge for this project was the CT Knowledge Transfer: Foundational Building Blocks model (Caltrans, 2014), which delineates the leadership steps for knowledge transference (p. 6). These steps are delineated as 1. "Mission and vision-stewardship and service- commitment and teamwork", 2. "Explicit knowledge: formal training and manuals", 3. "Tacit knowledge: Face to face-multimedia-rotational programs (cooperation of parties and resources)", and 4. "Informed and engaged workforce" (Caltrans, 2014, pp.6-8).

Empowerment evaluation. The theoretical process for the evaluation of the TIC workgroups experience in the project align with the Empowerment Evaluation concepts which involves the new use of evaluation concepts, techniques, and findings to foster improvement and self-determination" where the work group participants are empowered in their "control", and "increase resource allocation", and gain understanding of their "social" environment (Stoto & Cosler, 2008, p.522). Through the utilization of Empowerment theoretical concepts in the work group dynamic, the participants' self- confidence can be enhanced which promotes a behavioral change in managing one's environment (Tol, Alhani, Shojacazadeh, Sharifirad & Moazam,

2015). Empowerment is a dynamic process that can be utilized for outcome measurement from a collaborative, participatory, internally driven change process (Woodall, Raine, South, & Warwick-Booth, 2010). The theme of empowerment for the project evaluation framework aligns with the ethical underpinnings of public health promotion where respect, collaboration, and participation are central to the individual or group change processes (Tengland, 2012), which activities contribute to maintaining the integrity of the TIC assumptions and practice principles (SAMHSA, 2014b), as well as developing a work environment that helps eliminate organizational status and power imbalances (Browne et al., 2012).

Data Analysis

All project data were coded into statistical software, and multiple data entry checks were performed. Descriptive statistical analyses were performed to evaluate the data. Before descriptive statistical analysis occurred, data cleaning was performed on all data input. Outliers were evaluated for exclusion and statistical analyses assumptions were considered. During the TIC work group meetings (September, 2018 & February, 2019), the TIC work group completed the Fallot and Harris (2009) Self-Assessment and Planning Scale 1.4 for TIC culture subdomain scores (N=44), Domain total scores (N=6), and a scaled total score. The score method was performed by hand, and calculated in an Excel database. The scaled variables were then transcribed by the DNP student to SPSS 25 to create variable sets. The Artic 10 surveys were pre-numbered according to the number of participants, to maintain respondent anonymity. Notes from the work group meetings were recorded by hand by the work group participants, and were shared to the TIC work group participants through email. Work group meeting notes included meeting agenda, goals, and activities. Project publication of any TIC work group

meeting activities was approved by the TIC workgroup participants and the ACOO of the organization. Statistical analysis involved the use of SPSS 25.0 (IBM, 2018) software to run descriptive statistical analyses from the 2 Artic 10 survey instrument scores, from the Fallot and Harris (2009) CCTIC self-assessment and planning scores, and the TIC work group participant post project survey.

Ethical Considerations/Protection of Human Subjects

The project was not for investigational research purposes but was designed to transfer knowledge on the use of a TIC tool to the work group participants on how to plan, develop, and measure TIC culture in their organization. The DNP student reviewed the partnering organization's parent company's ethics and accountability code statements, and determined that the project activities were in alignment with said codes, as well as the partnering organization's strategic mission and values. All participants were protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) which, among other guarantees, protects the privacy of patients' health information detailed in the Modifications to the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules, 2013 (Department of Health and Human Services, 2013). IRB approval was obtained by the University of Massachusetts.

At the first meeting, this DNP student reviewed written information on the project goal and activities, on the data collection methods, and how data findings would be distributed. An informed consent form (see Appendix K) was distributed to all participants for participant staff review of project intention, design, and the right to voluntary consent or to decline project participation. The introduction of the consent form included a review of the steps of the project, the desired project goals and outcomes, and there was time allotted for potential participant's

questions and for the DNP student to provide answers. The materials for educational purposes, and the distribution of materials were peer reviewed and accepted for use among the trauma informed care education community (SAMHSA, 2014a; Trauma Informed Oregon, 2018; Yatchmenoff et al., 2017). All staff surveys omitted any personal identification, and survey data copied for use in reporting results remained anonymous, after receiving participants informed consent. Participant confidentiality was ensured by the coding of each of the participants surveys using survey identification numbers for data analysis or anonymous online survey data collection. Any electronic files containing identifiable information was password protected to prevent access by unauthorized users and only the DNP student had access to the password.

Trauma Informed Care is a strengths-based and positive support approach, which considers the importance of a person's health and wellbeing both personally and professionally (Decandia et al., 2014). The DNP student did not distribute any questionnaires (including the adverse childhood event questionnaire) that elicited trauma background information in order to protect the participants from trauma triggering stressors that could not be therapeutically supported in the project activities. Participation in the TIC work group was voluntary, and participants were informed that they could opt out of the project at any time during the information session, and throughout the project implementation activities. The participating staff's wellbeing was of special consideration during the project, and was supported through SAMHSA's guidance on how to care for the student (work group participants) during trauma informed care education (National Center for Trauma Informed Care, 2015). During the project, no direct interaction with the organization's client population, nor any discussion of any client's health, or any collection of staff or client's personal data occurred.

Results

Data was collected and evaluated from the nine work group participants completion of the online demographic survey, ARTIC 10 scales completed by the work group participants pre-post project, from the October, 2018, and February, 2019 CCTIC scores, and from the work group participants project feedback online survey.

Workgroup Participant Demographic Data

An anonymous demographic survey was distributed to the nine workgroup participants through survey monkey in August, 2018. Of the nine work group participants, eight responses were collected for demographic data analysis. To accurately represent the work group characteristics, eight ID numbers were entered to represent the eight work group participants. The one non-respondent was coded with the eight respondents into SPSS data editor with a numerical value (N = 9), and the coded variables labels were entered as “No Answer” to the survey questions. Collected demographic data (See Appendix L) included gender, age group, years of education, years of partnering organization employment, and whether the participant had previous TIC education (answer = yes /no). From data analysis (See Figure 2), the majority of the work group was female (78 %), white (78 %), with a Bachelor’s degree or higher level of education (67 %). The results are presented below:

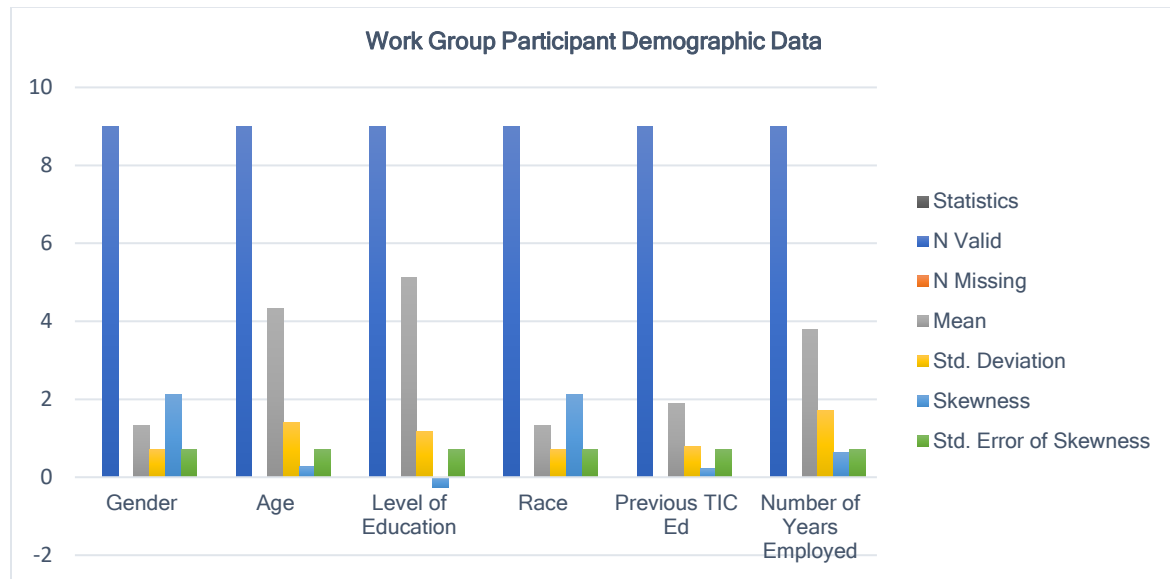


Figure 2. Average for each Demographic category: **Gender:** $M = 1.33$, $SD = 0.71$ (Female), **Age:** $M = 4.33$, $SD = 1.41$ (Answers: 40-59 yrs.), **Level of Education:** $M = 5.11$, $SD = 1.16$ (Answers: Bachelor's degree), **Race:** $M = 1.33$, $SD = 0.70$ (White), **Previous TIC Education:** $M = 1.89$, $SD = 0.79$ (Answer: No), **Number of Years Employed:** $M = 3.78$, $SD = 1.71$ (Answer: 11-15 yrs.).

ARTIC 10 Scale

The ARTIC (Attitudes Related to Trauma Informed Care)10 scale (Baker & Brown, 2016) is a 10 item questionnaire in a 7-point bipolar Likert scale format (See Appendix M), where the respondent or respondents' answers are totaled for an overall mean score (Baker & Brown, 2016). The Traumatic Stress Institute: Klingberg Family Centers (2018) gave the DNP student permission to use the ARTIC 10 scale, with a waived fee to purchase the tool (see Appendix N for waiver and use permission). This tool is psychometrically validated for use in organizations for pre-post TIC education to measure favorable vs less than favorable TIC attitudes, and it is accepted for use in a human service organization.

The ARTIC 10 scale measures staff attitudes and beliefs under the 5 subscales of a longer ARTIC Scale version. The 5 main subscale items measure the unfavorable to favorable respondent attitudes of 1. Under lying causes of problem behavior, 2. Staff responses to problem

behavior, 3. On the job behavior, 4. Staff feeling of self-efficacy at work, 5. Staff reactions to the work. The overall score can be statistically analyzed to measure the presence of favorable or non-favorable TIC staff attitudes. Subscale item scores are useful in understanding the strengths and weakness in specific area among the scaled group, which could benefit organizations in understanding what barriers and facilitators are involved in building a TIC organization (Baker et al., 2015).

Of the 9 work group participants, 8 participants chose to complete the ARTIC 10 pre-post scales. The DNP student performed multiple checks for data entry accuracy before running descriptive statistical analysis. The DNP student entered the total ARTIC 10 scaled scores for each participant for the October, 2018 (N = 8) and February, 2019 (N = 8). The ARTIC 10 authors (Baker & Brown, 2016) provided coding instruction for the ARTIC 10 scale which include recoding specific subscale items (artic 2, 4, 6, 8, 9) to reverse coding to (1=7), (2=6), (3=5),(4=4), (5=3), (6=2), (7=1). This process is to ensure the bipolar scale data is coded to accurately reflect the direction of the TIC attitudes measured. Recoding was performed on the identified variables. Data frequency was repeated to check data validity before running further statistical analyses. Non-parametric statistical analyses were performed due to the small sample size, and the distribution characteristics of the variables. The DNP student performed the non-parametric Wilcoxon Signed Ranks test to evaluate whether the work group participants displayed a difference in the overall TIC attitudes scaled score results collected during pre-post project (September, 2018, February, 2019). Statistical analyses indicated a significant difference from the September, 2018 (*Mdn* = 2.00) and February, 2019 (*Mdn* = 4.33) participant scores. The ARTIC 10 scaled ranked values in six of the eight total ARTIC 10 paired participant scores increased, one participant's paired score had decreased, and one participant's paired scores were

of equal value, $Z = -2.028$, $p < 0.043$, $r = -0.03$. The overall Median ranks for the September, 2018 and February, 2019 ARTIC 10 work group participant pre-post total scaled scores ($N = 8$) are displayed in Table 1.

Table 1

Artic 10 Scaled Rank Scores for September, 2018 and February, 2019

Ranks		N	Mean Rank	Sum of Ranks
Artic Feb 2019 scores - Artic Sept 2018 scores	Negative Ranks	1 ^a	2.00	2.00
	Positive Ranks	6 ^b	4.33	26.00
	Ties	1 ^c		
	Total	8		

a. Artic Feb 2019 scores < Artic Sept 2018 scores,

b. Artic Feb 2019 scores > Artic Sept 2018 scores,

c. Artic Feb 2019 scores = Artic Sept 2018 scores.

The CCTIC Self-Assessment 1.4 Scale

During the months of October 2018, and February 2019, the work group participants completed the CCTIC Self-Assessment Scale 1.4 (Fallot & Harris, 2009), utilizing the accompanying CCTIC Self-Assessment and Planning Protocol (Fallot & Harris, 2009). The DNP student mentored the work group participants in the tool use during the October activity. In February, the work group participants autonomously completed the scale while the DNP student observed. The nature of the support from the DNP student for these activities developed from the initiation of the work group participants during the scoring. The work group participants CCTIC scale scoring is considered a subjective set of values determined by the work group participants, who represent organizational experts on their perception of their level of TIC at one point in

time. The scale has scoring instructions to guide the user in maintaining fidelity while scoring the subscale items.

The CCTIC Self-Assessment scale is a 5-point Likert scale, where 1 is the lowest value represented on each question ($N = 44$), and 5 is the highest cut off point. The DNP entered the October, 2018 (Readiness Phase) CCTIC Self-Assessment subscale scores ($N=44$), and the February, 2019 (Post-Implementation Phase) CCTIC Self-Assessment subscale scores ($N = 44$) into SPSS. Data frequency was performed to check for missing variables. All data was checked for errors, and descriptive statistical analysis was performed. The total scores for the October, 2018 ($N = 44$) and February, 2019 ($N = 44$) were entered as two variable data sets in SPSS to determine the rank the values. Non-parametric statistical analyses were performed due to the small sample size, and the distribution characteristics of the variables. The non-parametric Wilcoxon Signed Rank test was performed to determine whether there was a significant change in the organizations level of TIC culture from October, 2018 to February, 2019.

From the test results (See Table 2), the changes in the paired scale scores ($N = 44$) between October 2018, and February, 2019 were significant. There was a positive increase in the level of the TIC organizational culture for the CCTIC scale paired scores ($n = 24$) from October, 2018 to February 2019 ($Mdn = 12.50$), and 20 CCTIC scale paired scores were equivalent, ($Mdn = 0.00$) from October, 2018 to February, 2019, $Z = -4.34$, $p < 0.001$. The non-parametric statistical analyses results indicate that the Community organization's ranked CCTIC scale scores increased more than 50 % from October, 2018 to February, 2019 after the workgroup participants implemented their objectives to improve the level of TIC culture in the organization.

Table 2*Wilcoxon Signed Ranks Test Statistical Analyses Results*

<i>Ranks</i>		N	Mean Rank	Sum of Ranks
Feb domain scores - Oct domain scores	Negative Ranks	0 ^a	.00	.00
	Positive Ranks	24 ^b	12.50	300.00
	Ties	20 ^c		
	Total	44		

a. Feb domain scores < Oct domain scores

b. Feb domain scores > Oct domain scores

c. Feb domain scores = Oct domain scores

During the Implementation phase of the project, between the first and second CCTIC scale completion, the TIC work group participants implemented the following objectives for each of the six CCTIC domains (not all inclusive):

Domain 1. Program Procedures and Settings

1. A TIC walkthrough check list for the organization's programs was created to consider emotional and physical safety as well as a TIC designed environment.
2. The Program Member satisfaction survey was modified to include the five TIC domains.
3. A staff survey for the Professional Development Day was created to elicit feedback on the staff's perception of the work place under the five TIC principles.
4. TIC materials on the 5 TIC principles were disseminated to staff and the clients.

Domain 2. Formal Service Policies

1. A Policy for staff debriefing was developed.
2. A formal crisis policy was identified.
3. A TIC Service policy to represent the organization was developed.

Domain 3. Trauma Screening, Assessment, and Service Planning

1. A trauma resource list was generated for staff.
2. A TIC De-escalation Preference form was created.

Domain 4. Administrative Support

1. A question was added to the new client screening process to support trauma needs.
2. The ACOO has agreed to continue the TIC work group meetings.
3. The organization has tentatively agreed to fund a Train the Trainer program for key staff to attend.

Domain 5. Staff Trauma Training and Education

1. An initiative to support the clients' creation of individual art work was completed that represented the five TIC principles.
2. A TIC Kick Off Day for 275 employees was completed in February, 2019.
3. One of the work group participants presented at the TIC Kick Off event

Domain 6. Human Resources Policy

1. A staff interview template was modified to include a question in relation to TIC.

The TIC Work Group Participants Feedback Survey

A feedback survey was sent to the TIC workgroup participants through Survey Monkey at the end of the project. This survey was at the core of the project for the DNP student evaluation of the project outcome to evaluate data on whether the work group participants reported confidence to plan, develop and measure the level of TIC culture in their organization using the CCTIC tool (Fallot & Harris, 2009). The survey was designed by the DNP student to measure the work group participant's perception of their level of confidence to use the CCTIC

tool after the work group participants completion of the tool on 2 separate occasions, which occurred during October, 2018 (2 meetings), and February 2019 (1 meeting). The survey contained two questions for data analysis, and one comment box with a request for narrative feedback, which items are listed below:

1. What is your perception of your level of confidence in using the Fallot and Harris (2009) CCTIC tools in a work group setting to plan, develop, and measure the level of Trauma Informed Care culture in your organization?

Answer options: Not Confident, Confident, Very Confident

2. Would you recommend the continued use of the Fallot and Harris (2009) CCTIC tools to plan, develop, and measure the Trauma Informed Care culture in your organization?

Answer Options: Yes, No

3. Please provide any comments that you would like to share on your experience in the work group setting using the Fallot and Harris (2009) CCTIC tools to plan, develop, and measure TIC culture in your organization.

Participant responses were downloaded by the DNP student from Survey Monkey as anonymous data, and each survey response was numbered randomly for data entry. All data entries were checked and rechecked, and cross checked to the printed survey results. For statistical analyses, questions one and two were entered by the DNP student in the SPSS 25 statistical software with Likert Scale labels. Question 3 was not valid for statistical measurement. The DNP student entered the first variable for the participant's ID number, the second variable

for Question 1 (Not Confident = 1), (Confident = 2), (Very Confident = 3), the third variable for Question 2 (No =1), (Yes = 2). Descriptive statistics analysis for frequencies was performed to check data validity and descriptive statistical analyses. The non-parametric Chi-Square Goodness of Fit Test was performed for additional data analyses on the expected frequency distribution compared to the work group participants’ survey responses (N = 9) for question one and question two. Data from question three includes the participant’s comments during the TIC workgroup meetings (no statistical analyses performed).

For question one, the statistical data analysis results (see Figure 3) of the survey respondents’ (N = 9) answers included 0 % respondents who answered “Not Confident” (n = 0), 67 % of survey respondents answered “Confident” (n = 6), and 33 % of the survey respondents who answered “Very Confident” (n = 3). From the data analysis, 100 % of the work group participants (N = 9, M = 2.33, SD = .50) with a CI [2.0, 2.70] reported that they are confident to very confident to use the Fallot and Harris (2009) CCTIC tool to plan, develop, and measure the level of Trauma Informed Care culture in their organization.

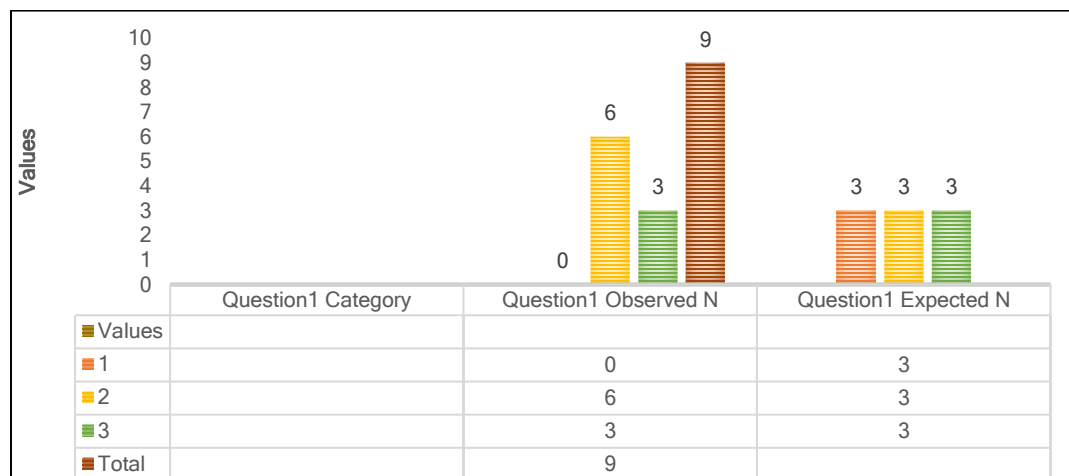


Figure 3. Question 1: Frequencies of Respondents Answers. Note: TIC Work Group Survey Question 1: Not Confident (n = 0. 0%), Confident (n = 33. %), Very Confident (n = 67 %), (M =2.33, SD = 0.50), $\chi^2(1, N = 9) = 6.0, p = 0.05$.

For question two, the statistical data analyses results (see Figure 4) of the survey respondents answers ($N = 9$, $M = 1.89$, $SD = .33$) and a $CI [1.67-2.10]$ included 11.1 % who answered “No” ($n = 1$) that they would not recommend the continued use of the CCTIC tool to plan, develop, and measure the Trauma Informed Care culture in their organization, and 88.9 % of the survey respondents ($n = 8$) who answered “Yes” that they would recommend the continued use the CCTIC tool to plan, develop, and measure the Trauma Informed Care culture in their organization.

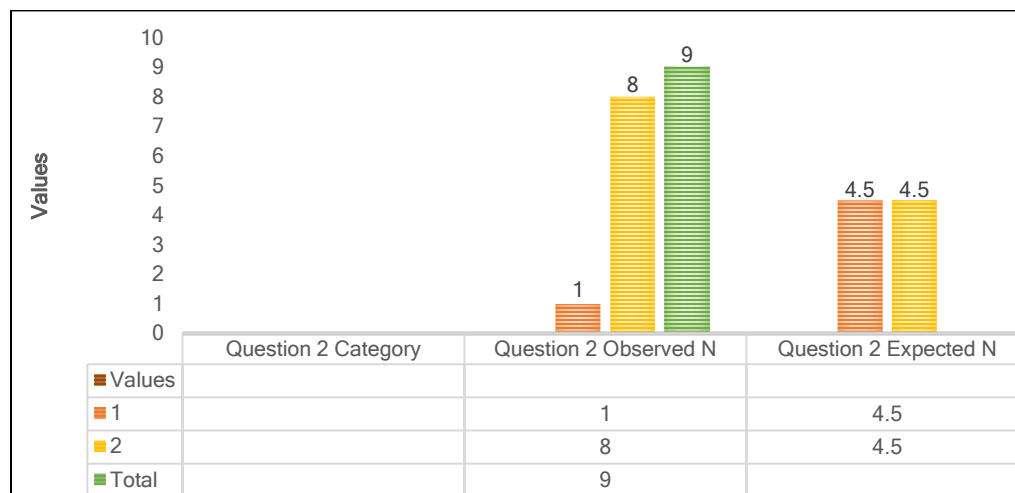


Figure 4. Question 2: Frequencies of Respondents Answers. Note: Does not recommend future use of CCTIC tool ($n = 1$, 11%), Does recommend future use of CCTIC tool ($n = 8$, 89 %), $M = 1.89$, $SD = 0.33$ (95% CI , LL 1.67 to UL 2.10), $\chi^2 (1, N = 9) = 5.44$, $p = 0.02$.

For the last question in the TIC work group survey, The DNP student included a comment box for respondents to comment on their experience in the work group setting using the Fallot and Harris (2009) CCTIC tools to plan, develop, and measure the level of TIC culture in your organization. The comments were collected for the DNP student’s review, and are displayed to offer value to the project results for participant feedback on their experience using the CCTIC tool. The respondents’ ($n = 4$) comments are listed below:

- “The Fallot and Harris Tool comprehensively looks at all aspects of an agency and is an effective tool to guide a TIC initiative”
- “I found it was a great tool to help us identify weak points in our organization and how to help both ourselves and fellow colleagues learn how to grow and best assist individuals”
- “I think it is a great tool to give precise visuals as to what our organization needs to work on, as well as what we’ve already achieved”
- “The Fallot and Harris scale helped us to guide our agency to systematically introduce TIC. The tool is critical in identifying the many areas of the agency that impact the successful adaptation of TIC into its culture”

Discussion

For this quality improvement public health initiative, the DNP student utilized qualitative research methods embedded in a grounded theoretical approach (Burns & Grove, 2007) to transfer knowledge to nine work group participants on how to plan, develop, and measure the level of TIC culture in their organization. This involved the DNP student’s provision of TIC education, TIC resources, mentorship, meeting facilitation, and expert guidance. Through the process of research translation and knowledge transference, a community public health initiative was designed and implemented to empower a community organization’s work group participants in TIC systems implementation to fill gaps in TIC practices in the provision of services to persons with an ID/DD diagnosis.

Knowledge Transference

Knowledge transference concepts (Caltrans, 2014, pp.6-8) were completed through the implementation of the project activities listed below:

- **Mission-commitment-teamwork:** The mission to transfer knowledge was confirmed with a project commitment from the newly formed organizational TIC workgroup. The work group participants attended the monthly meetings, and engaged in a team process for input, planning, and feedback to perform the project activities and to complete the TIC work group goals.
- **Explicit knowledge and use of a formal TIC tool:** The DNP student transferred knowledge to the work group on the Trauma Informed Oregon (2018a) road map, and the use of the Fallot and Harris (2009) CCTIC organizational self-assessment and planning tool. The SAMHSA (2015) educational materials were utilized by the DNP student for TIC education, with other miscellaneous TIC resources.
- **Tacit knowledge:** With the DNP student's support and interaction with the work group, the work group participants utilized their knowledge to measure the level of TIC culture in the organization in the initial and final stages of the project. In addition, interaction among workgroup participants involved activities to utilize the resources provided by the DNP student to transfer knowledge to each other and within the organization.
- **Informed and engaged workforce:** The TIC workgroup participated in the activities to gain knowledge on how to plan, develop, and measure the level of TIC culture in their organization through the experiential use of a TIC tool to implement changes in their organizational practices. Through work group outputs, organizational changes were made in organization.

Empowerment

Empowerment was the theoretical approach for the measure of TIC work group participants' perception of their level of confidence to utilize the Fallot and Harris (2009) CCTIC tool to plan, develop, and to measure TIC culture in their organization. The nine work group participants were empowered in gaining self- confidence in the use of a TIC systems implementation tool to build a TIC culture for improved service delivery (N =100%). By promoting empowerment theory into the transference of knowledge activities, the TIC work group participants had the opportunity to participate in the engagement process that contributes to establishing and sustaining a TIC work group environment (Tol et al., 2015). The empowerment evaluation steps are delineated below with the project outcomes (Stoto & Cosler, 2008, pp.522-523):

1. To “take stock” which represented the organization’s project commitment, and the work group participants’ contributions for the determination of meeting times, forms of communication, meeting location, and general activities.
2. “Focus on mission and establishing goals” represented the work group participants’ identification of the TIC indicator gaps from the use of the CCTIC tool (October, 2018).
3. “Develop strategies” represented the work group participants’ use of the Fallot and Harris (2009) CCTIC tool to create an action plan to improve the level of TIC culture in their organization during the implementation phase of the project (October, 2018-February, 2019).

4. “Monitor process and outcome measures to document progress towards goals” occurred through the TIC workgroup participants’ use of the CCTIC tool post-project to measure the difference in the level of TIC organizational culture (February, 2019).
5. “Communicate information to relevant audiences” was initiated with the TIC kickoff event, with TIC visual materials, and miscellaneous program activities. A TIC train the trainer implementation model is in the exploration phase for development for a community resource.
6. “Promote adaptation, renewal, and institutionalization” which occurred through the organizations commitment to continue the TIC work group meetings to continue to fill gaps in the level of TIC culture in the organization.

Barriers and Facilitators

Barriers involved work group participant absences at meetings due to unpredictable events such as weather, illness, and emergency activities. For TIC work group participants who missed a scheduled meeting, a copy of the work group meeting notes was distributed to all of the workgroup participants through email. The project was implemented on an accelerated timeline, which was a constraint for the organization’s optimal success, which was a subject of discussion during project planning and approved.

Other barriers included the internal bias’s and beliefs on trauma and its immediate and long- term effect on the population. The project was designed to address barriers in the TIC work group participants TIC attitudes and beliefs through TIC education. The DNP student

administered the ARTIC 10 attitudes and beliefs scale during the initial and final phases of the project for data on the progress for positive changes in participants TIC attitudes and beliefs.

From a review of the literature, the DNP student identified implementation barriers in building a TIC culture, which include a lack of top level organizational buy in, and staff access to a TIC specialist or mentor (Lang et al., 2016; Yatchmenoff et al., 2017). To address these barriers, the partnering organization's Assistant Chief Operating Officer (ACOO) reviewed and approved the preliminary project design and project requirements, and participated in the TIC workgroup meetings and activities.

Facilitator activities. For access to TIC expertise, direct mentorship was provided to the TIC workgroup participants during monthly TIC work group meetings. Mentorship activities included TIC education to the workgroup, distribution of TIC resources, guidance in following the Trauma Informed Care Road Map (Trauma Informed Oregon, 2018a), and facilitation of the Falloot and Harris (2009) CCTIC assessment tool. Outside of the work group meetings, additional mentorship included telephone and email contact. The level of effort and work output that the work group participants provided was a significant factor in project outcomes.

Cost-Benefit Analysis

Costs for the program involved the cost for printing and copying education materials, employee cost for participating in the education program, and the work time involved in participating in TIC committee activities (see Appendix N for Budget Tables). No additional costs were accrued for the use of a room for meetings, audio visual equipment, and education sessions because the rooms and equipment that were used are owned by the partnering organization. Travel costs were not incurred due to the DNP student's local access to the

organization and onsite activities occurred at the organization's site or nearby. The project benefits were immeasurable because they are embedded in a contribution of social and psychological assets which contribute to HRQOL and well-being measures (Division for Heart Disease and Stroke, 2017, slide 6-8). This theme also applies to the indirect benefits that could occur from the prevention of harm to the individuals which the organization provides services (Bassuk et al., 2017; Marcal & Trifoso, 2017; SAMHSA, 2014c).

Future Recommendations

Future recommendations include a project design with an adequate timeline for TIC systems implementation when using the CCTIC tool (Fallot & Harris, 2009), and the Trauma Informed Oregon (2018a) Roadmap. The DNP student's project was on an accelerated timeline to meet the DNP student's deadline, which added limitations to the project's Readiness and Implementation phase outcomes. Additional recommendations include a team approach for project design and implementation due to the extensive work load in managing the magnitude of project activities and project evaluation. Organizational buy in was a primary contribution to the project completion, and is a valuable factor in project planning. In duplication of this type of project, the inclusion of practices for the consideration of the project participants possible trauma past, of possible trauma triggering, the avoidance of harm for project participants is highly recommended.

Work group participant socio-demographic diversity was limited to the site's staff demographics and staff availability, and to staff willingness to participate in the project. Project methods are recommended to support a diverse work group participant representation, which was considered during the DNP project, and encouraged by the DNP student and the organization

within the staff volunteer pool. The size of the workgroup was not a barrier for project implementation, and instead, a benefit to make connections with the work group participants during the meetings, to disseminate project resources, and fit within the constraints for the DNP student's project coordination without additional supports. The size of the work group did limit the options for statistical analyses, which require identification within the project design before project implementation.

Project Dissemination

All project data findings were shared with the TIC workgroup participants for project completion of knowledge transference. This data included the overall September, 2018 and February, 2019 differences in the workgroups TIC ARTIC 10 attitudes and beliefs scores, the differences in the October, 2018 and February, 2019 CCTIC Self-Assessment scores, and the data findings from the TIC work group participant responses to the February, 2019 (post project) survey. The project results will be distributed to other undetermined key-stakeholders per the organization's determination. The DNP student has the organization's permission to publish the project to add research translation knowledge to benefit key-stakeholders beyond the immediate parties of interest.

Conclusion

The DNP student had the privilege to work with nine staff from the partnered organization, with the additional benefit of the use of the organization's resources. Methods for project implementation included tacit and explicit knowledge transference, and the use of empowerment evaluation concepts. The project was designed to fit the specific organization's

setting, and the DNP student was familiar with the population that the organization provides services to. Project implementation success is attributed to the formal commitment and support from the organization, the work group participant's continued commitment to meet and participate during the project phases, and participant flexibility. The work group participants were considered experts on their organization's operational systems and setting, and were empowered through the project to address gaps in TIC systems operations. Upon project completion, favorable TIC attitudes and beliefs evolved, the level of the organization's TIC culture increased, and the TIC work group participants gained confidence in the future use of a TIC systems tool to plan, develop, and to measure the level of TIC culture within their organization.

Individuals who are diagnosed with ID/DD are a vulnerable population with a higher incidence of traumatic life events than the general population. An accepted public health intervention for populations who are at a high risk for trauma is the implementation of trauma informed care. There is a gap in system implementation of trauma informed care in organizations that provide services to vulnerable populations, including individuals with ID/DD. Through the practice of TIC knowledge transference through TIC education, the facilitation of TIC implementation resources and a formal TIC tool with expert mentorship to an organization; an organizational work group can participate in a knowledge transference process to gain confidence in the use of a formal TIC systems tool to plan, develop, and measure the level of TIC culture in their organization. These activities can aid in increasing the quality of TIC interactions during service delivery, which promote increased opportunities for HRQOL and wellbeing outcomes, and decrease the likelihood of causing harm among staff and the people they serve.

References

- Agency for Healthcare Research and Quality. (n.d.). *How a trauma-informed approach can make a difference*. Retrieved from <http://innovations.ahrq.gov>
- Azeem, M. W., Reddy, B., Wudarsky, M., Carabetta, L., Gregory, F., & Sarofin, M. (2015). Restraint reduction at a pediatric psychiatric hospital: A ten-year journey. *Journal of Child and Adolescent Psychiatric Nursing*, 28(4), 180–184. <https://doi.org/10.1111/jcap.12127>
- Baker, C. N., & Brown, S. (2016). Measuring trauma-informed care: Using the attitudes related to trauma- informed care (ARTIC) scale. New Britain, CT: Traumatic Stress Institute. Retrieved from http://traumaticstressinstitute.org/wp-content/uploads/2016/04/ARTIC-Webinar-2016_Final-number-2.pdf
- Baker, C. N., Brown, S., Wilcox, P., Overstreet, S., & Arora, P. (2015). Development and psychometric evaluation of the attitudes related to trauma-informed care (ARTIC) scale. *School Mental Health*, 8, 61–76. <https://doi.org/10.1007/s12310-015-9161-0>
- Bartlett, J. D., Barto, B., Griffin, J. L., Fraser, J. G., Hodgdon, H., & Bodian, R. (2016). Trauma-informed care in the Massachusetts child trauma project. *Child Maltreatment*, 21(2), 101–112. <https://doi.org/10.1177/1077559515615700>
- Bassuk, E. L., Latta, R. E., Sember, R., Raja, S., & Richard, M. (2017). Universal design for underserved populations : person- centered , recovery- oriented and trauma informed. *Journal of Health Care for the Poor and Underserved: Project Muse*, 28(3), 896–914. <https://doi.org/https://doi.org/10.1353/hpu.2017.0087> For

- Berg, K. L., Shiu, C. S., Acharya, K., Stolbach, B. C., & Msall, M. E. (2016). Disparities in adversity among children with autism spectrum disorder: A population-based study. *Developmental Medicine & Child Neurology*, *58*, 1124–1131.
<https://doi.org/10.1111/dmcn.13161>
- Bigby, C., & Beadle-Brown, J. (2016). Improving quality of life outcomes in supported accommodation for people with intellectual disability: What makes a difference? *Journal of Applied Research in Intellectual Disabilities*, 1–19. <https://doi.org/10.1111/jar.12291>
- Brown, S. M., Baker, C. N., & Wilcox, P. (2012). Risking connection trauma training: A pathway toward trauma-informed care in child congregate care settings. *Psychological Trauma: Theory, Research, Practice, and Policy*, *4*(5), 507–515.
<https://doi.org/10.1037/a0025269>
- Browne, A. J., Varcoe, C. M., Wong, S. T., Smye, V. L., Lavoie, J., Littlejohn, D., ... Lennox, S. (2012). Closing the health equity gap: Evidence-based strategies for primary health care organizations. *International Journal for Equity in Health*, *11*(1), 59.
<https://doi.org/10.1186/1475-9276-11-59>
- Burns, N., & Grove, S. K. (2007). *Understanding nurse research: Building an evidence-based practice* (4th ed.). St Louis, Missouri: Saunders Elsevier.
- Caltrans. (2014). Knowledge transfer guidebook: Inform & engage. Retrieved from http://www.dot.ca.gov/docs/ct_knowledge_transfer_guidebook.pdf
- Carroll-Chapman, S. L., & Wu, L. T. (2012). Substance abuse among individuals with intellectual

disabilities. *Research on Developmental Disabilities*, 33(4), 1–21.

<https://doi.org/10.1016/j.ridd.2012.02.009>. Substance

Center for Substance Abuse Treatment (US). (2014). Understanding the impact of trauma. In *trauma-informed care in behavioral health services*. Rockville, MD: Substance Abuse and Mental Health Services Administration (SAMHSA). Retrieved from <https://www.ncbi.nlm.nih.gov/books/NBK207191/>

Commonwealth of Massachusetts. (2017). Trauma-informed training — DDS learning.

Retrieved November 21, 2017, from <http://ddslearning.com/traumainformed-training/>

Coughlan, M., Cronin, P., & Ryan, F. (2007). Step-by-step guide to critiquing research. Part 1: quantitative research. *British Journal of Nursing*, 16(11), 658–663.

<https://doi.org/10.12968/bjon.2007.16.11.23681>

Decandia, C. J., Guarino, K., & Clervil, R. W. (2014). *Trauma-informed care and trauma-specific services: A comprehensive approach to trauma intervention*. Washington, DC.

Retrieved from [http://www.air.org/sites/default/files/downloads/report/Trauma-Informed Care White Paper_October 2014.pdf](http://www.air.org/sites/default/files/downloads/report/Trauma-Informed%20Care%20White%20Paper_October%202014.pdf)

Department of Health and Human Services. (2013). Modifications to the HIPAA privacy, security, enforcement, and breach notification rules under the Health Information Technology for Economic and Clinical Health Act and the Genetic Information Nondiscrimination Act: Other modifications to the HIPAA rules, Pub. L. No. 45 CFR Parts 160 and 164, 78 Federal Register 1. Retrieved from <https://www.gpo.gov/fdsys/pkg/FR-2013-01-25/pdf/2013-01073.pdf>

Disability Justice. (2017). Abuse and exploitation of people with developmental disabilities.

Retrieved from <http://disabilityjustice.org/justice-denied/abuse-and-exploitation/>

Division for Heart Disease and Stroke. (2017). Part IV: Benefit-cost analysis: Outcomes

quantified in dollars: The fourth of a five-part series. CDC. Retrieved from

https://www.cdc.gov/dhdsdp/programs/spha/economic_evaluation/docs/podcast_iv.pdf

Fallot, R. D., & Harris, M. (2009). Creating cultures of trauma-informed care (CCTIC): A self-

assessment and planning protocol. San Francisco, CA: Jossey-Bass.

Federal Partners Committee on Women and Trauma. (2013). *Women and trauma:Trauma-*

informed approaches, federal activities and initiatives. Retrieved from

<https://www.nasmhpd.org/sites/default/files/2013FederalPartnersReportFinal.pdf>

Florida Developmental Disabilities Council, I. (2009). *Guidelines for understanding and serving*

people with intellectual disabilities and mental ,emotional ,and behavioral disorders. (C.

Putnam, Ed.). Human Systems and Outcomes, Inc.

Gray, T., & Tracey, D. K. (2016). Implementing a trauma informed framework in a disability

non-government organisation: Research report, 1–42. Retrieved from

https://www.westernsydney.edu.au/__data/assets/file/0010/1168066/GRAY_and_TRACEY

[_HWNS-Implementing_a_trauma_informed_framework_in_a_disability_non-](https://www.westernsydney.edu.au/__data/assets/file/0010/1168066/GRAY_and_TRACEY)

[government_organisation_RESEARCH_REPORT1.pdf](https://www.westernsydney.edu.au/__data/assets/file/0010/1168066/GRAY_and_TRACEY)

Healthy People 2020. (2010). *Health-related quality of life and well-being. Foundation health*

Measure Report. Retrieved from www.healthypeople.gov/2020/.../health-related-quality-of-

life-well-being

Healthy People 2020. (2017). Health-related quality of life and well-being. Retrieved from <https://www.healthypeople.gov/2020/about/foundation-health-measures/health-related-quality-of-life-and-well-being>

Hulbert-Williams, L., Hastings, R., Owen, D. M., Burns, L., Day, J., Mulligan, J., & Noone, S. J. (2014). Exposure to life events as a risk factor for psychological problems in adults with intellectual disabilities: A longitudinal design. *Journal of Intellectual Disability Research*, 58(1), 48–60. <https://doi.org/10.1111/jir.12050>

IBM. (2018). IBM SPSS statistics gradpack & faculty packs - Faq - United States. Retrieved from <https://www.ibm.com/us-en/marketplace/spss-statistics-gradpack/faq#product-header-top>

Institute on Community Integration: ICI. (2017). AA-AAS bibliography database. Minneapolis, MN: University of Minnesota: ICI. Retrieved from <https://ici.umn.edu/index.php?products/view/455>

Issel, L. M., & Wells, R. (2018). *Health program planning and evaluation: A practical, systematic approach for community health* (4th ed.). Burlington, MA: Jones & Bartlett Learning.

Jackson, A. L., & Waters, S. E. (2015). *Taking time framework: A trauma-informed framework for supporting people with intellectual disability*. Melbourne, AU. Retrieved from http://www.adhc.nsw.gov.au/__data/assets/file/0004/340447/Taking_Time_Framework.pdf

John F. Kennedy Presidential Library & Museum. (2017). John F. Kennedy and people with intellectual disabilities -. Retrieved from <https://www.jfklibrary.org/JFK/JFK-in-History/JFK-and-People-with-Intellectual-Disabilities.aspx>

Keesler, J. M. (2014a). A call for the integration of trauma-informed care among intellectual and developmental disability organizations. *Journal of Policy and Practice in Intellectual Disabilities*, 11(1), 34–42. <https://doi.org/10.1111/jppi.12071>

Keesler, J. M. (2014b). Trauma through the lens of service coordinators: exploring their awareness of adverse life events among adults with intellectual disabilities. *Advances in Mental Health and Intellectual Disabilities*, 8(3), 151–164. <https://doi.org/10.1108/AMHID-04-2013-0028>

Keesler, J. M., & Isham, C. (2017). Trauma-informed day services: An initial conceptualization and preliminary assessment. *Journal of Policy and Practice in Intellectual Disabilities*, 14(2), 164–175. <https://doi.org/10.1111/jppi.12206>

Klinic Community Health Centre. (2013). Trauma-informed: The trauma toolkit. *The Trauma Toolkit*, 2, 1–150. Retrieved from www.trauma-informed.ca

Krahn, G. L., & Fox, M. H. (2014). Health disparities of adults with intellectual disabilities : What do we know ? What do we do ?, 27(5), 431–446. <https://doi.org/10.1111/jar.12067>.Health

Lang, J. M., Campbell, K., Shanley, P., Crusto, C. A., & Connell, C. M. (2016). Building capacity for trauma-informed care in the child welfare system: Initial results of a statewide

implementation. *Child Maltreatment*, 21(2), 113–124.

<https://doi.org/10.1177/1077559516635273>

Latham-Hummer, V., Dollard, N., Robst, J., & Armstrong, M. I. (2010). Innovations in implementation of trauma-informed care practices in youth residential treatment: A curriculum for organizational change. *Child Welfare*, 89(2), 79–95.

Lavis, J. N., Robertson, D., Woodside, J. M., McLeod, C. B., Abelson, J., & Knowledge Transfer Study Group, K. T. S. (2003). How can research organizations more effectively transfer research knowledge to decision makers? *The Milbank Quarterly*, 81(2), 221–48, 171–2. <https://doi.org/10.1111/1468-0009.T01-1-00052>

Lounds Taylor, J., & Gotham, K. O. (2016). Cumulative life events, traumatic experiences, and psychiatric symptomatology in transition-aged youth with autism spectrum disorder. *Journal of Neurodevelopmental Disorders*, 8, 1–11. <https://doi.org/10.1186/s11689-016-9160-y>

Magruder, K. M., Kassam-Adams, N., Thoresen, S., & Olf, M. (2016). Prevention and public health approaches to trauma and traumatic stress: a rationale and a call to action. *European Journal of Psychotraumatology*, 7, 29715. <https://doi.org/10.3402/ejpt.v7.29715>

Magruder, K. M., McLaughlin, K. A., & Elmore-Borbon, D. L. (2017). Trauma is a public health issue. *European Journal of Psychotraumatology*, 8(1), 1–10. <https://doi.org/10.1080/20008198.2017.1375338>

Marcál, S., & Trifoso, S. (2017). A trauma-informed toolkit for providers in the field of

intellectual & developmental disabilities. Center for Disability Services. Retrieved from http://www.aceresponse.org/img/uploads/file/IDD_TOOLKIT_CFDS_HEARTS_NETWORK_5-28_FinalR2.pdf

Menschner, C., & Maul, A. (2016). Key ingredients for successful trauma informed care implementation. Center for Health Care Strategies; Robert Wood Johnson Foundation. Retrieved from <https://www.chcs.org/media/ATC-whitepaper-040616-rev.pdf>

National Center for Trauma Informed Care. (2015). NCTIC trauma curriculum instructor's guidance SAMHSA's trauma-informed approach: Key assumptions and principles. National Center for Trauma Informed Care. Retrieved from https://www.nasmhpd.org/sites/default/files/TraumaTIACurriculumTrainersManual%7B_%7D8%7B_%7D18%7B_%7D2015.pdf

Newhouse, R., Dearholt, S., Poe, S., Pugh, L. ., & White, K. (2005). The John Hopkins nursing evidence-based practice rating scale. Retrieved from [http://www.mc.vanderbilt.edu/documents/CAPNAH/files/Mentoring/Section 6/JHNEDP Evidence Rating Scale.pdf](http://www.mc.vanderbilt.edu/documents/CAPNAH/files/Mentoring/Section%206/JHNEDP%20Evidence%20Rating%20Scale.pdf)

Oral, R., Ramirez, M., Coohy, C., Nakada, S., Walz, A., Kuntz, A., ... Peek-Asa, C. (2016). Adverse childhood experiences and trauma informed care: the future of health care. *Pediatric Research*, 79(1), 227–233. <https://doi.org/10.1038/pr.2015.197>

Perrin, K. M. (2016). *Essentials of planning and evaluation for public health*. Burlington, MA: Jones & Bartlett Learning.

Peters, J., & Silvestri, F. (2016). *Healthy families: from ACEs to trauma informed care to resilience and wellbeing: Examples of policies and activities across IIMHL & IIDL countries. Make it so*. San Francisco. Retrieved from http://www.iimhl.com/files/docs/Make_It_So/20161206.pdf

Protection & Advocacy for People with Disabilities, I. (2017). History. Retrieved from <https://www.pandasc.org/about/history/>

Purtle, J., & Lewis, M. (2017). Mapping “trauma-informed” legislative proposals in U.S. congress. *Administration and Policy in Mental Health and Mental Health Services Research*, 44(6), 1–10. <https://doi.org/10.1007/s10488-017-0799-9>

Reardon R, Lavis J, & Gibson J. (2006). *From research to practice: A knowledge transfer planning guide*. Toronto, Ontario. Retrieved from www.iwh.on.ca

Salinas-Miranda, A. A., Salemi, J. L., King, L. M., Baldwin, J. A., Berry, E. “Lo,” Austin, D. A., ... Salihu, H. M. (2015). Adverse childhood experiences and health-related quality of life in adulthood: revelations from a community needs assessment. *Health and Quality of Life Outcomes*, 13(1), 123. <https://doi.org/10.1186/s12955-015-0323-4>

SAMHSA-HRSA. (2015). Improving health through trauma-informed care (pp. 1–55). Retrieved from https://www.integration.samhsa.gov/Trauma_Informed_Care_Webinar_Slides__072715.pdf

SAMHSA. (2014a). *A treatment improvement protocol (TIP) series 57: Trauma informed care in behavioral health services-a review of the literature* (HHS Public). Rockville, MD:

Department of Health and Human services.

<https://doi.org/10.1093/acrefore/9780199975839.013.1063>

SAMHSA. (2014b). *SAMHSA's concept of trauma and guidance for a trauma-informed approach*. HHS Publication No. (SMA) 14-4884. Rockville,MD. Retrieved from <https://store.samhsa.gov/shin/content//SMA14-4884/SMA14-4884.pdf>

SAMHSA. (2015). SAMHSA's trauma-informed approach: Key assumptions and principles. Retrieved from https://www.nasmhpd.org/sites/default/files/TIA_Training_PPT-8-17.pdf

Shojania, K. G., McDonald, K. M., Robert- Wachter, M. M., Owens, D. K., Markowitz, A. J., Robert Wachter, M. M., ... Markowitz, A. J. (2004). *Closing the quality gap: A critical analysis of quality improvement strategies, Volume 1-Series overview and methodology*. (Stanford–UCSF Evidence-based Practice Center, Ed.), *Agency for Healthcare Research and Quality* (Contract N). Rockville,MD: AHRQ. <https://doi.org/AHRQ> Publication No. 04-0051-1

Siron, C., Dagenais, V., & Ridde, S. (2015). What research tells us about knowledge transfer strategies to improve public health in low-income countries: a scoping review. *International Journal of Public Health*, 60, 849–863. <https://doi.org/10.1007/s00038-015-0716-5>

Special Olympics. (2009). Status and prospects of persons with intellectual disability. Retrieved from https://www.specialolympics.org/uploadedFiles/LandingPage/WhatWeDo/Research_Studies_Description_Pages/Policy_Paper_Status_Prospects.pdf

- Stoto, M. A., & Cosler, L. E. (2008). Evaluation of public health interventions. In L. F. Novick, C. B. Morrow, & G. . Mays (Eds.), *Public health administration : Principles for population-based management* (2nd ed., pp. 495–544). Sudbury, MA: Jones and Bartlett. Retrieved from https://www.researchgate.net/publication/260386924_Evaluation_of_public_health_interventions
- Strait, J., & Bolman, T. (2017). Consideration of personal adverse childhood experiences during implementation of trauma-informed care curriculum in graduate health programs. *The Permanente Journal*, 21. <https://doi.org/10.7812/TPP/16-061>
- SurveyMonkey. (2018). SurveyMonkey - Choose Collector. Retrieved from <https://www.surveymonkey.com>
- Tallant, B. (n.d.). Assessing trauma in individuals with ID. Aurora, CO: Association of University Centers on Disabilities.
- Tengland, P. A. (2012). Behavior change or empowerment: On the ethics of health-promotion strategies. *Public Health Ethics*, 5(2), 140–153. <https://doi.org/10.1093/phe/phs022>
- The Trauma Informed Care Project. (2017). TIC project related publications. Retrieved from <http://www.traumainformedcareproject.org/resources.php>
- Tol, A., Alhani, F., Shojaezadeh, D., Sharifirad, G., & Moazam, N. (2015). An empowering approach to promote the quality of life and self-management among type 2 diabetic patients. *Journal of Education and Health Promotion*, 4, 13. <https://doi.org/10.4103/2277->

9531.154022

- Tomlinson, M., Yasamy, M. T., Emerson, E., Officer, A., Richler, D., & Saxena, S. (2014). Setting global research priorities for developmental disabilities, including intellectual disabilities and autism. *Journal of Intellectual & Disability Research : JIDR*, 58(12), 1121–1130. <https://doi.org/10.1111/jir.12106>
- Trauma Informed Oregon. (2016). Trauma informed care workgroup meeting guidelines. Retrieved from <https://traumainformedoregon.org/wp-content/uploads/2016/01/Trauma-Informed-Care-Workgroup-Meeting-Guidelines.pdf>
- Trauma Informed Oregon. (2018a). Road map to trauma informed care. Retrieved from <https://traumainformedoregon.org/roadmap-trauma-informed-care/>
- Trauma Informed Oregon. (2018b). Roadmap to trauma informed care:Implementation process. Retrieved March 13, 2018, from <https://traumainformedoregon.org/roadmap-trauma-informed-care/>
- Traumatic Stress Institute: Klingberg Family Centers. (2018). To foster the transformation of organizations and service systems to trauma-informed care through the delivery of whole-system consultation, professional training, coaching and research. Retrieved from <http://traumaticstressinstitute.org/>
- U. S. Department of Health and Human Services:Health Resources and Services Administration (HRSA). (2011). *Quality improvement: Health care*. Retrieved from <https://www.hrsa.gov/sites/default/files/quality/toolbox/508pdfs/qualityimprovement.pdf>

- United Healthcare. (2016). *Quality improvement for individuals with intellectual & developmental disabilities: A proposed framework*. Retrieved from https://www.uhccommunityandstate.com/content/dam/community-state/PDFs/NAB_ID_DD_Whitepaper.pdf
- United Nations. (2006). United Nations convention on the rights of persons with disabilities. In *The U.N. Convention on The Rights of Persons with Disabilities* (pp. 1–28). United Nations. Retrieved from <http://www.un.org/esa/socdev/enable/rights/convtexte.htm>
- United States Department of Justice:National Institute of Corrections. (2017). Trauma annotated bibliography. National Institute of Corrections Information Center. Retrieved from <https://www.nicic.gov/Library/028314.pdf>
- University of South Florida: College of Behavioral & Community Sciences. (n.d.). Creating trauma-informed care environments: Organizational self-assessment for trauma informed care practices in youth residential settings. Retrieved from <http://www.cfbhn.org/Assets/TIC/youthresidentialself assess fillable form %282%29.pdf>
- Wigham, S., & Emerson, E. (2015). Trauma and life events in adults with intellectual disability. *Current Developmental Disorders Reports*, 2(2), 93–99.
- Wigham, S., Hatton, C., & Taylor, J. L. (2011). The effects of traumatizing life events on people with intellectual disabilities: A systematic review. *Journal of Mental Health Research in Intellectual Disabilities*, 4(1), 19–39. <https://doi.org/10.1080/19315864.2010.534576>
- Wisconsin’s Violence Against Women with Disabilities and Deaf Women Project: Disability

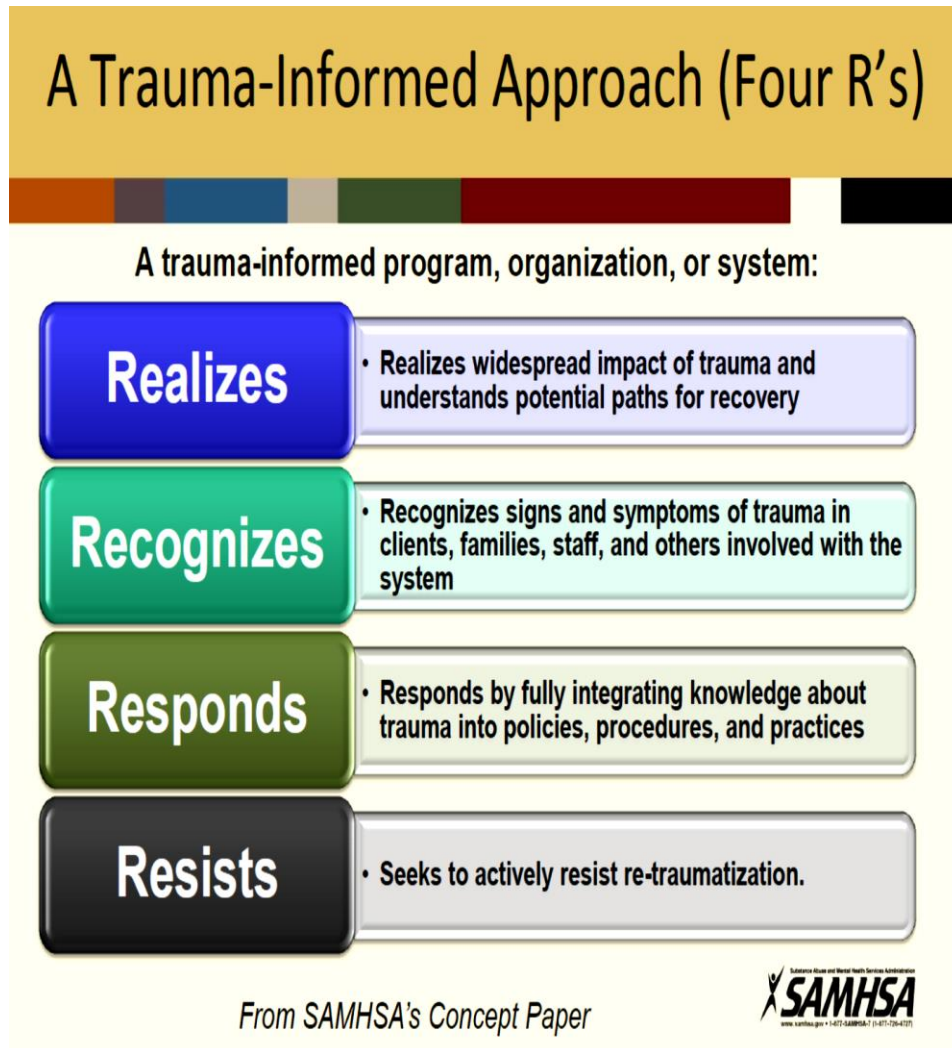
Rights Wisconsin Wisconsin Coalition Against Domestic Violence Wisconsin Coalition Against Sexual Assault. (2011). A practical guide for creating trauma-informed disability, domestic violence, and sexual assault organizations, 1–54. Retrieved from <http://www.disabilityrightswi.org/wp-content/uploads/2012/05/Trauma-Informed-Guide.pdf>

Woodall, J., Raine, G., South, J., & Warwick-Booth, L. (2010). Empowerment and health: Well-being evidence review. Centre for Health Promotion Research: Leeds Metropolitan University. Retrieved from [http://eprints.leedsbeckett.ac.uk/2172/1/FINAL EMPOWERMENT EVIDENCE REVIEW.pdf](http://eprints.leedsbeckett.ac.uk/2172/1/FINAL_EMPOWERMENT_EVIDENCE_REVIEW.pdf)

Yatchmenoff, D. K., Sundborg, S. A., & Davis, M. A. (2017). Implementing trauma-informed care: Recommendations on the process. *Advances in Social Work, 18*(1), 167–185. <https://doi.org/10.18060/21311>

Appendix A

SAMHSA TIC 4 Rs Conceptual Framework

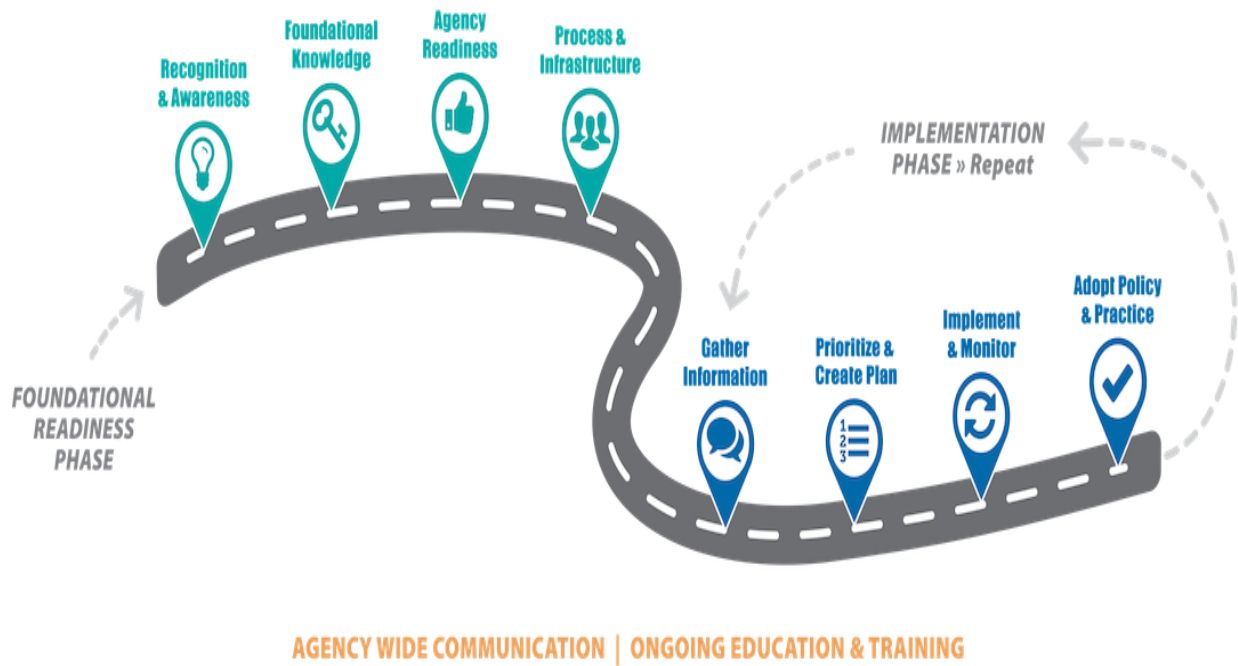


SAMHSA. (2014). *SAMHSA's concept of trauma and guidance for a trauma-informed approach*. HHS Publication No. (SMA) 14-4884. Rockville, MD. Retrieved from <https://store.samhsa.gov/shin/content//SMA14-4884/SMA14-4884.pdf>

Appendix B

Trauma Informed Oregon’s Road MAP to Trauma Informed Care

ROADMAP TO TRAUMA INFORMED CARE



Trauma Informed Oregon. (2018). Roadmap to trauma informed care: Implementation process. Retrieved March 13, 2018, from <https://traumainformedoregon.org/roadmap-trauma-informed-care/>

Appendix C-1

Trauma-Informed Program Self-Assessment Scale Version 1.4 (5-06)
Community Connections (DRAFT: Not for circulation without permission)

Domain 1. Program Procedures and Settings: “To what extent are program activities and settings consistent with five guiding principles of trauma-informed practice: safety, trustworthiness, choice, collaboration, and empowerment?”

Domain 1A. Safety—Ensuring Physical and Emotional Safety: “To what extent do the program’s activities and settings ensure the physical and emotional safety of consumers and staff?”

Criterion	1	2	3	4	5
1. Program Review: The program has conducted a specific and systematic review of its physical setting and its activities in order to evaluate its physical and emotional safety and to make changes necessary to ensure consumer and staff safety.	No specific, systematic review has been conducted.	A systematic program-wide review has been conducted, including both consumer-survivor and line staff input.	In addition to (2), an action plan to maximize safety has been developed.	In addition to (3), the action plan has been partially implemented.	In addition to (4), all steps of the action plan have been implemented.
2. Incident Review: The program systematically reviews those incidents that indicate a lack of safety (e.g., verbal and physical confrontations, assaults) and makes changes to prevent their recurrence.	No incident reviews have occurred.	A plan has been developed for identifying and reporting incidents that indicate a lack of safety (incl. both consumer and staff reports).	In addition to (2), a plan has been developed for clinical and administrative review of incidents that indicate a lack of safety.	In addition to (3), the plan has been implemented.	In addition to (4), the incident reviews are used to modify potentially unsafe practices or settings.
3. Consumer Ratings of Safety: In program satisfaction surveys, consumers rate program safety at the “agree” (or comparable, better than neutral) point on the rating scale or higher.	No consumers rate program safety at the “agree” or higher point.	Fewer than 40% of consumers rate program safety at the “agree” or higher point.	40-70% of consumers rate program safety at the “agree” or higher point.	71-90% of consumers rate program safety at the “agree” or higher point.	More than 90% of consumers rate program safety at the “agree” or higher point.
4. Staff Ratings of Safety: In staff surveys, staff rate program safety at the “agree” or comparable point on the rating scale or higher.	No staff members rate program safety at the “agree” or higher point.	Fewer than 40% of staff members rate program safety at the “agree” or higher point.	40-70% of staff members rate program safety at the “agree” or higher point.	71-90% of staff members rate program safety at the “agree” or higher point.	More than 90% of staff members rate program safety at the “agree” or higher point.

Appendix C-2

Trauma-Informed Program Self-Assessment Scale – Version 1.4 (5-06)
Community Connections (DRAFT: Not for circulation without permission)

Domain 1C. Choice—Maximizing Consumer Choice and Control. “To what extent do the program’s activities and settings maximize consumer experiences of choice and control?”

Criterion	1	2	3	4	5
1. <u>Program Review:</u> The program has conducted a <u>specific and systematic</u> review of its physical setting and its activities in order to evaluate consumer choice and control and to make changes necessary to maximize consumer choice.	No specific, systematic review has been conducted.	A systematic program-wide review has been conducted, including consumer-survivor input.	In addition to (2), an action plan to maximize consumer choice has been developed.	In addition to (3), the action plan has been partially implemented.	In addition to (4), all steps of the action plan have been implemented.
2. <u>Program Options:</u> Staff review the program’s service options (e.g., types of services offered, locations, housing possibilities, choices regarding clinicians) with each consumer prior to the development of an initial service plan.	Service options have been reviewed with no consumers.	Fewer than 30% of consumers have reviewed the program’s service options with staff.	30-60% of consumers have reviewed the program’s service options with staff.	61-90% of consumers have reviewed the program’s service options with staff.	More than 90% of consumers have reviewed the program’s service options with staff.
3. <u>Consumer Ratings of Choice and Control:</u> In program satisfaction surveys, consumers rate their experience of choice and control in the program at the “agree” (or comparable, better than neutral) point on the rating scale or higher.	No consumers rate consumer choice at the “agree” or higher point.	Fewer than 40% of consumers rate consumer choice at the “agree” or higher point.	40-70% of consumers rate consumer choice at the “agree” or higher point.	71-90% of consumers rate consumer choice at the “agree” or higher point.	More than 90% of consumers rate consumer choice at the “agree” or higher point.

Appendix C-3

Trauma-Informed Program Self-Assessment Scale Version 1.4 (5-06)
 Community Connections (DRAFT: Not for circulation without permission)

Domain 1D. Collaboration—Maximizing Collaboration and Sharing Power: “To what extent do the program’s activities and settings maximize collaboration and sharing of power between staff and consumers?”

Criterion	1	2	3	4	5
1. Program Review: The program has conducted a <u>specific and systematic</u> review of its activities in order to assess the quality of collaboration in staff-consumer relationships and to identify opportunities for enhancing this collaboration.	No specific, systematic review has been conducted.	A systematic program-wide review has been conducted, including consumer-survivor input.	In addition to (2), an action plan to maximize consumer-staff collaboration has been developed.	In addition to (3), the action plan has been partially implemented.	In addition to (4), all steps of the action plan have been implemented.
2. Consumer Ratings of Collaboration: Consumers rate the program and its staff as collaborative—sharing power and respecting consumer perspectives—at the “agree” (or comparable, better than neutral) point on the rating scale or higher.	No consumers rate program collaboration at the “agree” or higher point.	Fewer than 40% of consumers rate program collaboration at the “agree” or higher point.	40-70% of consumers rate program collaboration at the “agree” or higher point.	71-90% of consumers rate program collaboration at the “agree” or higher point.	More than 90% of consumers rate program collaboration at the “agree” or higher point.

Appendix C-4

Trauma-Informed Program Self-Assessment Scale Version 1.4 (5-06)
 Community Connections (DRAFT: Not for circulation without permission)

Domain 1E. **Empowerment**—Prioritizing Empowerment and Skill-Building: “To what extent do the program’s activities and settings prioritize consumer empowerment and growth?”

Criterion	1	2	3	4	5
1. Program Review: The program has conducted a <u>specific and systematic</u> review of its activities in order to assess the extent to which the program facilitates consumer empowerment and skill-building and to identify opportunities for enhancing this priority.	No specific, systematic review has been conducted.	A systematic program-wide review has been conducted, including consumer-survivor input.	In addition to (2), an action plan to maximize consumer empowerment and skill-building has been developed.	In addition to (3), the action plan has been partially implemented.	In addition to (4), all steps of the action plan have been implemented.
2. Identifying Consumer Strengths: The program identifies each consumer’s strengths and resources as part of routine assessment.	No consumer’s assessment has identified strengths and resources.	Fewer than 30% of consumers’ assessments have identified strengths and resources.	30-60% of consumers’ assessments have identified strengths and resources.	61-90% of consumers’ assessments have identified strengths and resources.	More than 90% of consumers’ assessments have identified strengths and resources.
3. Consumer Ratings of Empowerment: Consumers rate the program and its staff as facilitating empowerment and skill-building at the “agree” (or comparable, better than neutral) point on the rating scale or higher.	No consumers rate consumer empowerment and skill-building at the “agree” or higher point.	Fewer than 40% of consumers rate consumer empowerment and skill-building at the “agree” or higher point.	40-70% of consumers rate consumer empowerment and skill-building at the “agree” or higher point.	71-90% of consumers rate consumer empowerment and skill-building at the “agree” or higher point.	More than 90% of consumers rate consumer empowerment and skill-building at the “agree” or higher point.

Appendix C-5

Trauma-Informed Program Self-Assessment Scale Version 1.4 (5-06)

Community Connections (DRAFT: Not for circulation without permission)

Domain 2. Formal Service Policies: “To what extent do the formal policies and procedures of the program reflect an understanding of trauma and recovery?”

Criterion	1	2	3	4	5
1. Eliminating Involuntary Treatment: The program has developed written policies that seek to eliminate involuntary or coercive practices (seclusion and restraint, involuntary hospitalization or medication, outpatient commitment).	No relevant policies have been developed.	Policies designed to eliminate involuntary treatment have been developed.	In addition to (2), policies are consistently implemented.	In addition to (3), instances of involuntary treatment are regularly reviewed in order to improve practice.	In addition to (4), survivor-consumers are routinely involved in this review of both policy and practice.
2. Consumer Crisis Preferences (A): The program has a written policy and formal procedure for inquiring about and respecting consumer preferences for responding in crisis situations.	No policy or procedure has been developed.	A relevant policy, specifying a procedure (e.g., a standard form) for inquiring about consumer crisis preferences, has been developed.	In addition to (2), this procedure includes steps to ensure the staff’s awareness of and attention to these preferences.	In addition to (3), instances of crisis response are regularly reviewed in order to ensure consideration of consumer preferences.	In addition to (4), crisis response procedures are adjusted as necessary to maximize attention to consumer preferences.
3. Consumer Crisis Preferences (B): Each consumer has been asked about crisis preferences and their responses are available to all appropriate direct service staff.	No consumer is asked about crisis preferences.	Fewer than 30% of consumers are asked OR their preferences are not known by all relevant staff.	30-60% of consumers are asked OR 30-60% of consumer preferences are known by all relevant staff.	61-90% of consumers are asked OR 61-90% of consumer preferences are known by all relevant staff.	More than 90% of consumers are asked AND more than 90% of consumer preferences are known by all relevant staff.
4. De-escalation Policy: The program has a written de-escalation policy that minimizes possibility of retraumatization; the policy includes reference to a consumer’s statement of preference for crisis response.	No written de-escalation policy exists.	The program has a written de-escalation policy that minimizes retraumatization and includes consumer crisis preferences.	In addition to (2), this policy is regularly implemented.	In addition to (3), de-escalation situations are regularly reviewed in order to ensure attention to consumer preferences.	In addition to (4), the de-escalation policy is adjusted as necessary to maximize attention to consumer preferences.

Appendix C-6

Trauma-Informed Program Self-Assessment Scale Version 1.4 (5-06)
 Community Connections (DRAFT: Not for circulation without permission)

<u>Criterion</u>	1	2	3	4	5
5. Confidentiality (A): Policies regarding confidentiality (including limits) and access to information are clearly written and maximize legal protection of consumer privacy.	No written confidentiality policy exists OR it is written in a way difficult for consumers to understand.	A written confidentiality policy exists and is clearly written.	In addition to (2), the policy maximizes the legal protection of consumer privacy.	In addition to (3), instances that reflect limits of confidentiality are routinely reviewed.	In addition to (4), confidentiality policy is adjusted to maximize clarity and consumers' privacy within legal limits.
6. Confidentiality (B): Program confidentiality policies, including limits of confidentiality, are communicated to each consumer.	No consumer has been given information about confidentiality and its limits.	Fewer than 30% of consumers have been given information about confidentiality and its limits.	30-60% of consumers have been given information about confidentiality and its limits.	61-90% of consumers have been given information about confidentiality and its limits.	More than 90% of consumers have been given information about confidentiality and its limits.
7. Consumer Rights and Responsibilities (A): The program has a clearly written and easily accessible policy outlining consumer rights and responsibilities.	No written consumer rights and responsibilities policy exists OR it is written in a way difficult for consumers to understand.	A written statement of consumer rights and responsibilities exists and is clearly written.	In addition to (2), the statement is readily available for consumers.	In addition to (3), the statement is reviewed for possible revision on at least an annual basis.	In addition to (4), consumer-survivors are involved in the writing of the statement.
8. Consumer Rights and Responsibilities (B): The program's policy regarding consumer rights and responsibilities has been communicated to each consumer.	No consumer has been given the statement of rights and responsibilities.	Fewer than 30% of consumers have been given the statement.	30-60% of consumers have been given the statement.	61-90% of consumers have been given the statement.	More than 90% of consumers have been given the statement AND the statement is posted publicly.

Appendix C-7

Trauma-Informed Program Self-Assessment Scale Version 1.4 (5-06)
 Community Connections (DRAFT: Not for circulation without permission)

Domain 3. Trauma Screening, Assessment, and Service Planning: “To what extent does the program have a consistent way to identify individuals who have been exposed to trauma and to include trauma-related information in planning services with the consumer?”

Criterion	1	2	3	4	5
1. Universal Trauma Screening: Within the first month of service participation, every consumer has been asked about exposure to trauma.	No consumer has been asked about trauma exposure.	Fewer than 30% of consumers have been asked, within the first month of service participation, about trauma exposure.	30-60% of consumers have been asked about trauma exposure.	61-90% of consumers have been asked about trauma exposure.	More than 90% of consumers have been asked about trauma exposure.
2. Trauma Screening Content: The trauma screening includes questions about lifetime exposure to sexual and physical abuse.	No standardized trauma screening approach exists.	A standardized screening for trauma has been approved but not implemented.	A standardized screening approach has been implemented but does not include questions about sexual or physical abuse.	The screening includes questions about EITHER sexual abuse OR physical abuse OR about abuse in general OR about a specific time period.	The standardized screening includes questions about lifetime exposure to both physical and sexual abuse
3. Trauma Screening Process: The trauma screening is implemented in ways that minimize consumer stress; it reflects considerations given to timing, setting, relationship to interviewer, consumer choice about answering, and unnecessary repetition.	No discussion of the screening process has occurred.	A plan for minimizing stress in screening has been developed.	A screening plan that includes flexible responses to consumers has been implemented.	The screening process is routinely reviewed to ensure that it minimizes consumer and staff distress.	Consumers and staff report satisfaction with the screening process.

Appendix C-8

Trauma-Informed Program Self-Assessment Scale Version 1.4 (5-06)
 Community Connections (DRAFT: Not for circulation without permission)

Domain 4. Administrative Support for Program-Wide Trauma-Informed Services: “To what extent do agency administrators support the integration of knowledge about trauma and recovery into all program practices?”

Criterion	1	2	3	4	5
1. Written Policy Statement: The program has adopted a formal policy statement that refers to the importance of trauma and the need to account for consumer experiences of trauma in all aspects of program operation.	No senior level discussion has occurred.	Senior level administrators have participated in discussion of statement.	In addition to (2), administrators have reviewed draft statement.	In addition to (3), administrators have approved adoption of statement.	In addition to (4), statement is prominently displayed in program description.
2. Support for Trauma-Informed Leadership: The program has named a trauma specialist or workgroup(s) to lead agency activities in trauma-related areas and provides needed support for trauma initiatives.	No trauma specialist or workgroup has been identified.	Specialist or workgroup has been identified and given a clear mission.	In addition to (2), resources (staff time, budget) have been allocated.	In addition to (3), action plan has been adopted and initial steps taken.	In addition to (4), initial action plan has been substantially completed.
3. Administrative Participation in and Oversight of Trauma-Informed Approaches: Program administrators monitor and participate actively in responding to the recommendations and activities of the trauma leadership.	No reporting or monitoring of trauma-related activities occurs.	Administrators are informed of trauma specialist or workgroup activities.	In addition to (2), administrators meet periodically with trauma specialist or workgroup.	In addition to (3), administrators routinely monitor implementation of trauma activities.	In addition to (4), administrators include trauma initiatives in formal reports and publications.
4. Trauma Survivor-Consumer Involvement (A): Administrators work with a Consumer Advisory Board (CAB) that includes consumers who have had lived experiences of trauma.	No Consumer Advisory Board exists.	Consumer Advisory Board exists but has no self-identified trauma survivor-consumers.	Consumer Advisory Board has one member who self-identifies as a survivor-consumer.	Consumer Advisory Board has at least two members who self-identify as survivor-consumers.	In addition to (4), administrators ensure that trauma initiatives are addressed in meetings with the CAB.
5. Trauma Survivor-Consumer Involvement (B): Consumers who have had lived experiences of trauma are actively involved in all aspects of program planning and oversight.	No survivor-consumers are involved in program or agency planning.	Survivor-consumer workgroup has been formed.	In addition to (2), this workgroup makes recommendations to administrators regarding trauma initiatives.	In addition to (3), survivor-consumers are represented on major agency standing committees.	In addition to (4), survivor-consumers have paid positions in the agency; positions draw explicitly on lived experience.

Appendix C-9

Trauma-Informed Program Self-Assessment Scale Version 1.4 (5-06)
 Community Connections (DRAFT: Not for circulation without permission)

<u>Criterion</u>	1	2	3	4	5
6. Needs Assessment and Program Evaluation: Program gathers data addressing the needs and strengths of consumers who are trauma survivors and evaluates the effectiveness of the program and trauma-specific services.	No data are gathered.	The program has gathered data regarding prevalence of trauma and needs of survivors.	In addition to (2), the program has developed a plan to monitor the process (incl. consumer satisfaction) and outcomes of trauma services.	In addition to (3), the program regularly monitors process and outcomes.	In addition to (4), the program incorporates program evaluation results in its planning for trauma-related services.
7. Trauma and Consumer Satisfaction: Administrators include at least five key principles of trauma-informed services in consumer satisfaction surveys: safety, trustworthiness, choice, collaboration, and empowerment (see Domain 1).	None of the five areas is included in surveys (or surveys are not standardized).	One of the areas is included in surveys.	Two or three of the areas are included in surveys.	Four of the areas are included in surveys.	All five of the areas are included in surveys.

Appendix C-10

Trauma-Informed Program Self-Assessment Scale Version 1.4 (5-06)
Community Connections (DRAFT: Not for circulation without permission)

Domain 5. Staff Trauma Training and Education: “To what extent have all staff members received appropriate training in trauma and its implications for their work?”

Criterion	1	2	3	4	5
1. General Trauma Education for All Staff (A): All staff (including administrative and support personnel) have participated in at least three hours of “basic” trauma education that addresses at least the following: a) trauma prevalence, impact, and recovery; b) ensuring safety and avoiding retraumatization; c) maximizing trustworthiness (clear tasks and boundaries); d) enhancing consumer choice; e) maximizing collaboration; and f) emphasizing empowerment.	No trauma education designed for all staff has been offered.	Fewer than 30% of staff have participated in basic trauma education OR more than 50% of staff have received trauma education that includes only one of the content areas.	30-60% of staff have participated in basic trauma education OR more than 50% of staff have received trauma education that includes two or three of the content areas.	61-90% of staff have participated in basic trauma education OR more than 50% of staff have received trauma education that includes four or five of the content areas.	More than 90% of staff have participated in basic trauma education that includes all six content areas.
2. General Trauma Education for All Staff (B): All new staff receive at least one hour of trauma education as part of orientation.	No new staff have received trauma education in orientation.	Fewer than 30% of staff have received trauma education in orientation.	30-60% of staff have received trauma education in orientation.	61-90% of staff have received trauma education in orientation.	More than 90% of staff have received trauma education in orientation.
3. Education for Direct Services Staff (A): Direct service staff have received at least three hours of education involving trauma-informed modifications in their content areas (e.g., care coordination, housing, substance use).	No direct services staff have received this education.	Fewer than 30% of direct services staff have received this education.	30-60% of direct services staff have received this education.	61-90% of direct services staff have received this education.	More than 90% of staff have received this education.
4. Education for Direct Services Staff (B): Direct service staff have received at least three hours of education involving trauma-specific techniques (e.g., grounding, teaching trauma recovery skills).	No direct services staff have received this education.	Fewer than 30% of these staff have received this education.	30-60% of direct services staff have received this education.	61-90% of direct services staff have received this education.	More than 90% of staff have received this education.
5. Support for Direct Services Staff: Direct service staff offering trauma-specific services are provided adequate resources for self-care, including supervision, consultation, and/or peer support that addresses secondary traumatization.	No specific support for direct services staff is offered.	Administrators have developed a plan for offering support.	General support is offered but does not address secondary traumatization.	Trauma-focused support is offered and made accessible for staff.	Staff report that trauma-focused support is adequate to meet their needs.

Appendix C-11

Trauma-Informed Program Self-Assessment Scale Version 1.4 (5-06)
 Community Connections (DRAFT: Not for circulation without permission)

Domain 6. Human Resources Practices: “To what extent are trauma-related concerns part of the hiring and performance review process?”

Criterion	1	2	3	4	5
1. Prospective Staff Interviews: Interviews include trauma-related questions. (What do applicants know about trauma, including sexual and physical abuse? About its impact? About recovery and healing? Is there a “blaming the victim” bias? Is there potential to be a trauma “champion?”)	Interviews do not address trauma.	Fewer than 30% of interviews address trauma.	30-60% of interviews address trauma.	61-90% of interviews address trauma.	More than 90% of interviews address trauma.
2. Staff Performance Reviews: Staff performance reviews include trauma-informed skills and tasks, including the development of safe, trustworthy, collaborative, and empowering relationships with consumers that maximize consumer choice.	Performance reviews do not address trauma-informed skills.	Fewer than 30% of performance reviews address trauma-informed skills.	30-60% of performance reviews address trauma-informed skills.	61-90% of performance reviews address trauma-informed skills.	More than 90% of performance reviews address trauma-informed skills.

Appendix C-12

Trauma-Informed Program Self-Assessment Scale Version 1.4 (5-06)
Community Connections (DRAFT: Not for circulation without permission)

Agency/Program _____ Date _____

Person(s) Completing Scale: _____

Domain 1. Program Procedures and Settings

1A 1. _____	1C 1. _____	
1A 2. _____	1C 2. _____	
1A 3. _____	1C 3. _____	
1A 4. _____	1D 1. _____	
1B 1. _____	1D 2. _____	
1B 2. _____	1E 1. _____	
1B 3. _____	1E 2. _____	
1B 4. _____	1E 3. _____	Domain 1 Subtotal _____

Domain 2. Formal Services Policies

1. _____	5. _____	
2. _____	6. _____	
3. _____	7. _____	
4. _____	8. _____	Domain 2 Subtotal _____

Domain 3: Trauma Screening, Assessment, and Service Planning

1. _____	4. _____	
2. _____	5. _____	
3. _____	6. _____	Domain 3 Subtotal _____

Domain 4: Administrative Support for Program-Wide Trauma-Informed Services

1. _____	5. _____	
2. _____	6. _____	
3. _____	7. _____	
4. _____		Domain 4 Subtotal _____

Domain 5: Staff Trauma Training and Education

1. _____	4. _____	
2. _____	5. _____	
3. _____		Domain 5 Subtotal _____

Domain 6: Human Resources Practices

1. _____	2. _____	Domain 6 Subtotal _____
----------	----------	-------------------------

Grand Total _____

Appendix D

CCTIC Permission to Use the Falloot and Harris (2009) Self-Assessment and Planning Scale

Hi Lisa,

You have our permission to use our Creating Cultures of Trauma Informed Care program self-assessment scale, and we hope you will keep in touch with us regarding your experience with the tools and if you publish any work we would appreciate you sharing that with us.

Lori L. Beyer, LICSW

Director of Trauma Training

Community Connections, Inc.

801 Pennsylvania Ave SE, Suite 201

Washington, DC 20003

202-608-4788 telephone

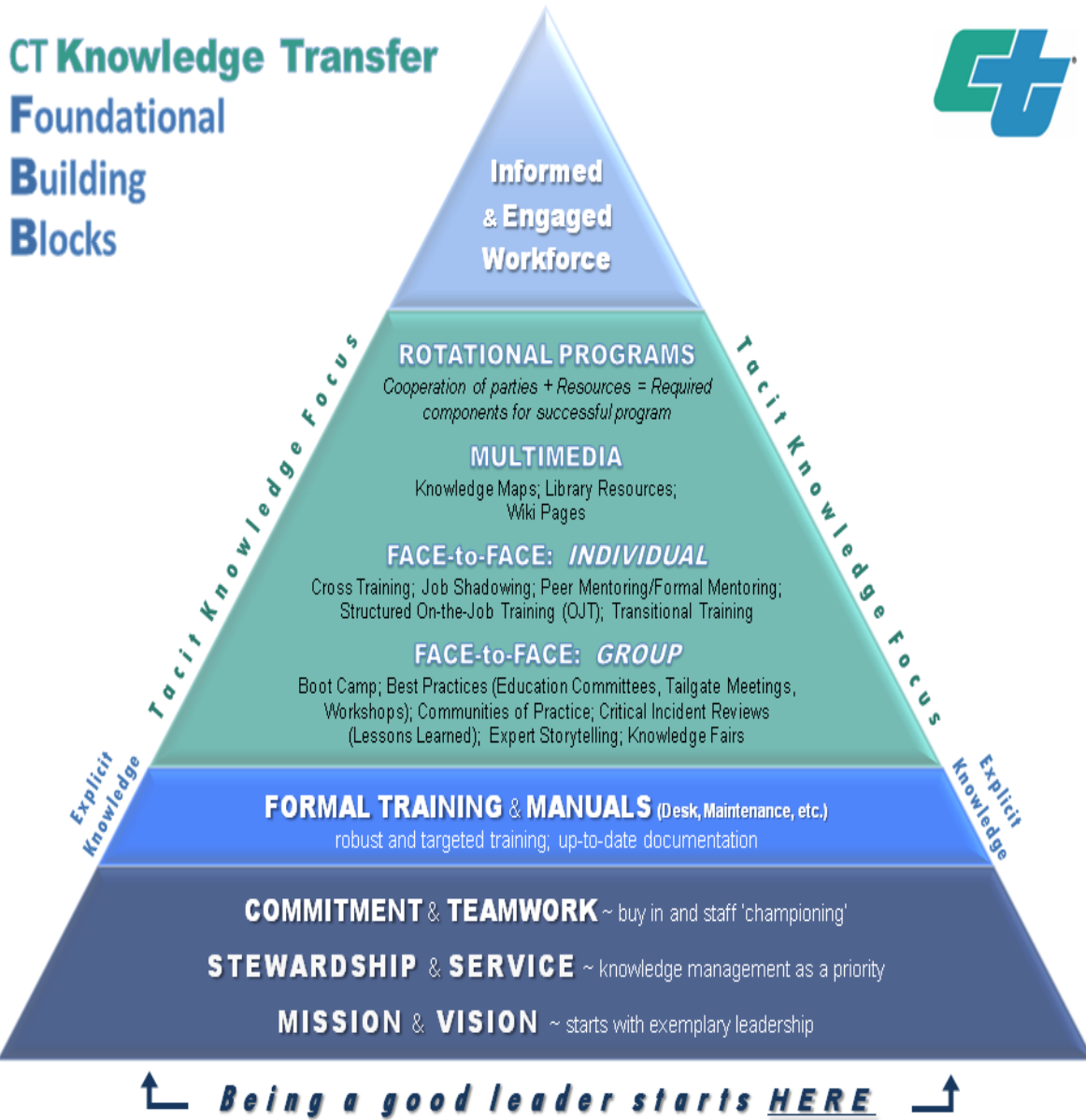
202-608-4286 fax

lbeyer@ccdcl.org



Appendix E

Caltrans Knowledge Transfer Framework



Caltrans. (2014). Knowledge transfer guidebook: Inform & engage. Retrieved from http://www.dot.ca.gov/docs/ct_knowledge_transfer_guidebook.pdf

Appendix F

Timeline



Appendix G

Trauma Informed Care Binder Table of Content

Work Group Planning, Development, and Evaluation Book
Table of Contents

Foundational Readiness Phase

1. [Recognition & Awareness](#)
2. [Foundational Knowledge](#)
3. [Agency Readiness](#)
4. [Process & Infrastructure](#)

Implementation Phase

1. [Gather Information](#)
2. [Prioritize & Create Work Plan](#)
3. [Implement & Monitor](#)
4. [Adopt Policy & Practice](#)
5. [Agency wide Communication](#)
6. [Ongoing Education & Training](#)

Appendix H

Trauma Informed Care Workgroup Meeting Guidelines

As TIC Workgroups form and begin to gather information, identify opportunities, set priorities for change, and propose solutions, there are a number of considerations that can help keep the process on track. We recommend using or adapting some of the questions below to set guidelines for Workgroup meetings.

- 1) Are enough people in the meeting, with enough diversity in roles and responsibilities, to ensure we are representing different experiences and points of view?
 - a. If not, what is our plan to remedy this?
 - b. Are we able to move forward anyway, and if so, with what considerations?
- 2) Are we using a trauma informed process as we make decisions in this meeting?
 - a. Is our process inclusive (making sure everyone in the room has a chance to be heard and that the discussion is not dominated by one or two members)?
 - b. Are we spending enough time processing different views and perspectives?
 - c. Have we openly discussed issues of safety and power; do we have a plan to make this process as safe as possible for all?
- 3) Are we making space for individuals to “check in” so that we’re hearing what is most immediately on the minds of participants?
 - a. Are we limiting the time for check-in appropriately so that we move towards action steps as well?
- 4) Are we continuing to educate ourselves so that we can take the lead with others in our agency/program/clinic?
 - a. Do we start with appreciations or observations of trauma informed practice we’ve observed since our last meeting?
 - b. Do we link the challenges we see and want to address back to the impact of trauma (for example, “How is this activating circumstance linked to the impact of trauma? Why would this issue be especially important to address because we are working with survivors/victims of trauma?”).
 - c. Are we taking up other activities (for example, sharing articles or other information sources) to continue our education?
- 5) As we come up with priorities and/or solutions, do we have a process to share those ideas/recommendations with the larger community as well as with senior management?
 - a. What’s our communication process? What will be included?
 - b. Who is responsible?
 - c. When will it happen?
 - d. If we’re asking for feedback, how will we use it?
 - e. Are we using this communication to continue education for all staff and leadership about trauma and trauma informed care?
- 6) Have we talked about how we will handle conflict or differences of opinion in the Workgroup?
 - a. If we have created norms around conflict, are we following them?

Trauma Informed Oregon. (2016). Trauma informed care workgroup meeting guidelines. Retrieved from <https://traumainformedoregon.org/wp-content/uploads/2016/01/Trauma-Informed-Care-Workgroup-Meeting-Guidelines.pdf>

Appendix I-1

Work Group Demographic Survey

U.S. Demographics – Snapshot Survey

Question Title

1. What is your gender?

- Female
- Male
- Other (specify)

Question Title

2. Which category below includes your age?

- 18-20
- 21-29
- 30-39
- 40-49
- 50-59
- 60 or older

Appendix I-2

Work Group Demographic Survey

Question Title

3. What is the highest level of school you have completed or the highest degree you have received?

- Less than high school degree
- High school degree or equivalent (e.g., GED)
- Some college but no degree
- Associate degree
- Bachelor degree
- Graduate degree

Question Title

4. Are you White, Black or African-American, American Indian or Alaskan Native, Asian, Native Hawaiian or other Pacific islander, or some other race?

- White
- Black or African-American
- American Indian or Alaskan Native
- Asian
- Native Hawaiian or other Pacific Islander
- From multiple races
- Some other race (please specify)

Appendix I-3

Work Group Demographic Survey

Question Title

5. Are you Mexican, Mexican-American, Chicano, Puerto Rican, Cuban, Cuban-American, or some other Spanish, Hispanic, or Latino group?

- I am not Spanish, Hispanic, or Latino
- Mexican
- Mexican-American
- Chicano
- Puerto Rican
- Cuban
- Cuban-American
- Some other Spanish, Hispanic, or Latino group
- From multiple Spanish, Hispanic, or Latino groups

Appendix I-4

Work Group Demographic Survey

Question Title

6. What is your role in the organization?

Question Title

7. Have you had any trauma informed education before this project?

Yes

No

Question Title

8. How long have you worked for the organization?

less than 1 year

1-5 years

6-10 years

11-15 years

16-20 years

more than 20 years

DONE

Appendix J

TIC Work Group Feedback Survey

Question Title

1. What is your perception of your level of confidence in using the Fallot and Harris (2009) CCTIC tools in a work group setting to plan, develop, and measure the level of Trauma Informed Care culture in your organization?

Not Confident

Confident

Very Confident

2. Would you recommend the continued use of the Fallot and Harris (2009) CCTIC tools to plan, develop, and measure the Trauma Informed Care culture in your organization?

Yes

No

3. Please provide any comments that you would like to share on your experience in the work group setting using the Fallot and Harris (2009) CCTIC tools to plan, develop, and measure TIC culture in your organization.



DONE

Appendix K-1

Trauma Informed Care Project Informed Consent Form

Lisa Coenen, RN, DNP-PHNL graduate student, University of Massachusetts: Amherst

This informed consent form is for all of the TIC work group participants that were invited to participate in this project, and may include administrative staff, management, clinicians, direct care staff, human resources, and any other staff representing staff duties not otherwise specified.

Name of DNP student: Lisa Coenen

Name of Organization: Identified Organization

Name of Project: Building a trauma informed care organization: Knowledge transference of the use of a trauma informed care organizational assessment and planning tool to a community organization that provides services to individuals with developmental and intellectual diagnoses

This Informed Consent Form has two parts:

1. Information Sheet (to share information about the project with you)
2. Certificate of Consent (for signatures if you choose to participate)

You will be given a copy of the full Informed Consent Form to review and keep

Appendix K-2

Trauma Informed Care Project Informed Consent Form

Part I: Information Sheet

Hi,

My name is Lisa Coenen. I am currently working on my Capstone project for the completion of my UMASS Amherst Public Health Nurse Leadership Doctoral program. For my Capstone project, I am doing a community- based work group project on mentoring an organization in the use of a tool to plan, develop, and to measure the level of TIC in an organization. Trauma informed care is a universal approach that encompasses recognizing the possibility of a trauma past in the population the organization supports, realizing the impact trauma has on people's lives, and responding to the trauma with a TIC approach that promotes safety, trust, empowerment, choice, and collaboration in all aspects of the organization's service delivery. The project activities involve 8 monthly or bi-monthly work group meetings (2 hours), where the participants will receive or will participate in:

1. TIC education from the DNP student.
2. TIC education on the use of specific tools to build a TIC culture in the organization.
3. Participant use of a TIC culture measurement tool during 2 project phases.
4. Workgroup collaboration for meeting agenda, goals, and organization activities in TIC implementation.
5. A demographic survey distributed online through survey monkey, that will ask general questions about your gender, work role, age, education, number of years with the organization, and whether you have had TIC education in the past.
6. An online survey distributed at the end of the project that will ask you questions about your perception of your confidence in using the designated tool to plan, develop, and measure TIC culture in your organization, and whether you would recommend future use of the tool.

Any or all survey question responses are voluntary, and will be kept anonymous. All data collected during the workgroup will be kept in a secured location. The DNP student has ensured steps in data collection to maintain your anonymity in all data that is collected, stored, and prepared for dissemination to the workgroup and for future publication (with your consent). Your participation in this project is voluntary, and your contributions to this project are valued. You have the right to drop out of the work group at any time. Questions, concerns, and participant feedback are an important process in this project, and are encouraged during all meetings. The DNP student is available by email or for a personal meeting to discuss any questions or concerns that you would like discuss, which will remain confidential. Before you decide, you can talk to anyone you feel comfortable with about the project and your desire to choose whether you would like to participate.

Appendix K-3

Trauma Informed Care Project Informed Consent Form

This consent form may contain words that you do not understand. Please ask me to stop as we go through the information and I will take time to explain.

Risks

There is a risk that participating in this project might elicit trauma triggers for you. The first meeting will involve a trauma work group participant care plan to support all the participants in any discomfort or emotional disruptions that you or they may experience. Your wellbeing is a priority, and the program coordinator is available to support you in finding the resources and the supports that you might need during the course of this project. If at any time, you determine that it is in your best interest to discontinue participation in the work group activities, you are welcome to take a break, leave the meeting, or discontinue work group participation. The DNP student will continue to be available to you, whether you continue in the program or not, to discuss any questions or concerns that you might have.

Benefits

The benefits in participating in this project include the opportunity to gain TIC knowledge, to learn how to practice TIC self-care, and to build a work group relationship with your peers. Another benefit is the contribution that you can make in building a TIC workplace that can increase the quality of TIC services for the staff and the individuals that the Center of Hope supports.

Reimbursements

The TIC work group participants are not expected to perform any work group duties beyond their assigned roles at their workplace. There is not any project compensation (monetary or otherwise) involved in TIC workgroup participation beyond the organization's contracted employment agreement for designated employee work hours.

This project is built upon a focused work group process: Focus workgroups operate in sharing information. With this consideration, there is the possibility that personal information might be shared. The DNP student or participants will not be allowed to document any personal information shared, and there will be strict confidentiality expectations delineated for work group participation. With this in mind, complete confidentiality of personal information shared cannot be guaranteed to be protected, although all efforts will be made to ensure this process.

Appendix K-4

Trauma Informed Care Project Informed Consent Form

Part II: Certificate of Consent

I, _____ have been invited to participate in the trauma informed workgroup, that will occur 1-2 x per month for 10 months (August, 2018-March, 2019) during work hours. I have agreed to participate under a voluntary process in the workgroup, and I understand that I can drop out of the project at any time. I understand that I can contact the DNP student by email or in person with any questions or concerns that I may have regarding the project. I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it and any questions I have been asked have been answered to my satisfaction.

By signing this form, I consent voluntarily to be a participant in this project

Print Name of Participant: _____

Signature of Participant: _____

Date: _____

Day/month/year

Appendix K-5

Trauma Informed Care Project Informed Consent Form

Statement by the DNP student taking consent

I have accurately read out the information sheet to the potential participant, and to the best of my ability made sure that the participant understands that the following will be done:

1. Option for voluntary participation was explained
2. Questions and concerns were addressed
3. Confidentiality is considered, protected, but cannot be guaranteed
4. The participant's wellbeing during project activities is addressed through a workgroup care planning process to include workgroup supports, support resources (provided on request), and open contact with the DNP student

I confirm that the participant was given an opportunity to ask questions about the project, and all the questions asked by the participant have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily. A copy of this ICF has been provided to the participant.

Print Name of person taking the consent_____

Signature of person taking the consent_____

Date _____

Appendix L

TIC Work Group Participants' Demographic Data Results

Gender

		Frequency	Percent
Valid	Female	7	77.8
	Male	1	11.1
	No Answer	1	11.1
	Total	9	100.0

Age

		Frequency	Percent
Valid	21-29 yrs.	1	11.1
	30-39 yrs.	1	11.1
	40-49 yrs.	3	33.3
	50-59 yrs.	3	33.3
	No Answer	1	11.1
	Total	9	100.0

Level of Education

		Frequency	Percent
Valid	Some college but no degree	1	11.1
	Associate degree	1	11.1
	Bachelor's degree	4	44.4
	Graduate degree	2	22.2
	No Answer	1	11.1
	Total	9	100.0

Race

		Frequency	Percent
Valid	White	7	77.8
	Not White	1	11.1
	No Answer	1	11.1
	Total	9	100.0

Number of Years Employed

		Frequency	Percent
Valid	1-5 yrs.	3	33.3
	6-10 yrs.	1	11.1
	11-15 yrs.	2	22.2
	16-20 yrs.	2	22.2
	No Answer	1	11.1
	Total	9	100.0

Appendix M

The Artic 10 Scale Staff Attitudes and Belief



Attitudes Related to Trauma-Informed Care Scale
VERSION: ARTIC-10 HUMAN SERVICES



TRAUMATIC STRESS
INSTITUTE

People who work in human services, health care, education, and related fields have a wide variety of beliefs about their clients, their jobs, and themselves. The term “client” is interchangeable with “student,” “person,” “resident,” “patient,” or other terms to describe the person being served in a particular setting.

Trauma-informed care is an approach to engaging people with trauma histories in human services, education, and related fields that recognizes and acknowledges the impact of trauma on their lives.

INSTRUCTIONS

For each item, select the circle along the dimension between the two options that best represents your personal belief during the past two months at your job.

Sample

1 2 3 4 5 6 7

Ice cream is delicious ○ ● ○ ○ ○ ○ ○ Ice cream is disgusting.

Note: In this SAMPLE ITEM, the respondent is reporting that he/she believes that ice cream is much more delicious than disgusting.

I believe that...

1 2 3 4 5 6 7

1	Clients could act better if they really wanted to.	○ ○ ○ ○ ○ ○ ○	Clients are doing the best they can with the skills they have.
2	Focusing on developing healthy, healing relationships is the best approach when working with people with trauma histories.	○ ○ ○ ○ ○ ○ ○	Rules and consequences are the best approach when working with people with trauma histories.
3	If clients say or do disrespectful things to me, it makes me look like a fool in front of others.	○ ○ ○ ○ ○ ○ ○	If clients say or do disrespectful things to me, it doesn't reflect badly on me.
4	The ups and downs are part of the work so I don't take it personally.	○ ○ ○ ○ ○ ○ ○	The unpredictability and intensity of work makes me think I'm not fit for this job.
5	It's best not to tell others if I have strong feelings about the work because they will think I am not cut out for this job.	○ ○ ○ ○ ○ ○ ○	It's best if I talk with others about my strong feelings about the work so I don't have to hold it alone.
6	Clients do the right thing one day but not the next. This shows that they are doing the best they can at any particular time.	○ ○ ○ ○ ○ ○ ○	Clients do the right thing one day but not the next. This shows that they could control their behavior if they really wanted to.
7	Clients need to experience real life consequences in order to function in the real world.	○ ○ ○ ○ ○ ○ ○	Clients need to experience healing relationships in order to function in the real world.
8	I realize that clients may not be able to apologize to me after they act out.	○ ○ ○ ○ ○ ○ ○	If clients don't apologize to me after they act out, I look like a fool in front of others.
9	I feel able to do my best each day to help my clients.	○ ○ ○ ○ ○ ○ ○	I'm just not up to helping my clients anymore.
10	The most effective helpers find ways to toughen up – to screen out the pain – and not care so much about the work.	○ ○ ○ ○ ○ ○ ○	The most effective helpers allow themselves to be affected by the work – to feel and manage the pain – and to keep caring about the work.

Thank you for your participation.



Developed and copyrighted by the Traumatic Stress Institute of Klingberg Family Centers in partnership with Dr. Courtney N. Baker, Tulane University. 370 Linwood Street, New Britain, Connecticut 06052 | (860) 832-5562 | artic@klingberg.org | www.traumaticstressinstitute.org

Appendix N

Permission to Use the Artic 10 Scale with Waived Fee

Hi Lisa,

Given your situation and current scope of use, your request for a waived fee has been approved with the same guidelines for use as the full price; you are permitted to use the ARTIC for up to 600 respondents or 5 sites, and you may administer the ARTIC within that group as many times as you'd like. If your scope ever grows beyond that, we ask that you renegotiate with us.

Please find attached the ARTIC in all its standard versions, along with scoring spreadsheet and instructions. If you are interested in using the ARTIC in an online format, we have a Qualtrics-compatible version we can share with you at no additional cost. If you'd like to use the ARTIC in a different online survey format, you are welcome to do so if you maintain the fidelity of the questions and answer scales, but we do not help you with that process. Let me know if you'd like to have that version.

Sincerely,

Chris Greene

Administrative Assistant

Traumatic Stress Institute of Klingberg Family Centers

370 Linwood Street, New Britain, CT 06052

tsisupport@klingberg.com

P: 860-832-5562 /F: 860-471-8226

Appendix O

Cost Analysis

Project Participants/ Personnel

Position	Name	Annual Salary/Rate	Level of Effort	Cost
(1) DNP student	Lisa Coenen	\$50.00 /Hour	278 hours	\$13,900
(2) Identified Organization	Not disclosed	General ACOO rate \$120,000/annually	50 hours	\$2,885
(3) 30 Organizational staff	Not disclosed	Average of range of rate \$13.00/Hour	3 hours	\$1, 170
(4) Organizational staff for TIC meetings including clinicians and managers	Not disclosed	Average of range of rate \$25.00 / Hour	2 hours x 10 months	\$500
			TOTAL	\$18,455

Supplies and Equipment

Item(s)	Rate	Cost
General office supplies	\$20/mo. x 10 mo.	\$200
Postage	0	0
Laptop Computer	\$700	700
Printer	\$200	\$200
Projector with screen	\$900	\$900
Copies	500 copies x .10/copy	\$50.00
TOTAL		\$2,050

Space for Meetings and Education Session

Item	Rate	Cost
(1) Rent*	\$3.00/sq. Ft x 700 sq. feet= 2100,00	\$2,100
(2) Telephone	0	0
(3) Table and Chairs	\$500	\$500
Total		\$2,600

Proposed Project Period

Start Date:	08/26/2018	End Date:	02/30/2019
Category		Total Project Costs	
Personnel	\$18,455	\$18,455	
Equipment and supplies	\$2,050	\$20,505	
Room and accommodations	\$500.00	\$20,605	
Total Project Costs		\$20,605	