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Disclaimer

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ABOUT BRSS TACS

In September 2011, the Substance Abuse and Mental Health Services Administration (SAMHSA) awarded the Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS) contract to the Center for Social Innovation (C4). The funding award, through C4 and its partners, established the BRSS TACS team, a consortium dedicated to promoting wide-scale adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental health conditions. The BRSS TACS team includes:

- Abt Associates
- Advocates for Human Potential
- Boston University Center for Psychiatric Rehabilitation
- Faces and Voices of Recovery
- JBS International
- National Coalition for Mental Health Recovery
- National Federation of Families for Children’s Mental Health
- National Association of State Alcohol and Drug Abuse Directors
- National Association of State Mental Health Program Directors
- New York Association of Psychiatric Rehabilitation Services
- Pat Deegan Associates

BRSS TACS encourages and supports the widespread adoption of recovery-oriented services and systems of care across the United States. BRSS TACS serves as a coordinated effort to bring recovery to scale, leveraging past and current accomplishments by SAMHSA and others in the behavioral health field. These efforts are an important mechanism for coordinating and implementing SAMHSA’s Recovery Support Strategic Initiative. Through the Recovery Support Strategic Initiative and other efforts, SAMHSA supports a high quality, self-directed, and satisfying life in the community for all people in recovery.
BACKGROUND AND MEETING CONTEXT

A universal cry has arisen for more responsive and compassionate health care (Agency for Healthcare Research and Quality [AHRQ], 2009a, 2009b; Institute of Medicine [IOM], 2001, 2010; World Health Organization, 2008). Currently, the U.S. healthcare system is fragmented, hierarchical, symptom-focused, and financially driven, which has led to diminished quality of care, barriers to access, lack of continuity of care, and low satisfaction among people accessing services (AHRQ, 2009a, 2009b; IOM, 2001, 2010). The Institute of Medicine (IOM) observed in its report Crossing the Quality Chasm: A New Health System for the 21st Century (2001) that “between the health care we have and the care we could have lies not just a gap but a chasm” (p. 1).

To begin to remedy the quality chasm, the IOM report (2001) recommended that “continuous healing relationships” (p. 3) become the centerpiece of a widespread transformation of health care. The notion of “continuous healing relationships” breaks with the convention of acute episodic care and instead, stresses wellness. It brings practitioners and people seeking services into collaborations that encompass the “qualities of compassion, empathy, and responsiveness to the needs, values, and expressed preferences of the individual patient” (IOM, 2001, p. 48). It also emphasizes the importance of understanding the social and cultural context of a person’s life and the social determinants of disease.

A series of critical realignments results from forming collaborations between practitioners and people accessing services:

- People accessing services, rather than professionals, control their care.
- Practitioners prioritize the needs and values of people accessing services.
- Partners share knowledge and decisions.
- Practitioners document the narratives of people accessing services.

This emphasis on long-term engagement between people accessing services and practitioners—and their resulting empowerment—offers a framework for redesigning the U.S. healthcare system. The principles of person-centered care,1 an age-old approach to high-quality, compassionate care, best embody this shift. As Epstein and Street (2011) remind us:

“The originators of client-centered and patient-centered health care were well aware of the moral implications of their work, which was based on deep respect for patients as unique living beings, and the obligation to care for them on their own terms” (p. 100).

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1 The principles of person-centered care are described on pages 9–10.
Despite growing attention to person-centered care, this approach has yet to be widely implemented in hospital systems (Davis, Stremikis, Schoen, & Squires, 2014; Hagenow, 2003). Although all people interacting with care systems are affected when systems do not adopt these approaches, the negative effect of this failure falls disproportionately on those marginalized by race, sexual orientation, socioeconomic status, and type of illness (Epstein, Fiscella, Lesser, & Stange, 2010; Fiscella & Epstein, 2008; IOM, 2003; Mayer et al., 2008). Systems and services that are not person-centered may affect individuals with mental health conditions and substance use disorders (behavioral health conditions) and those with trauma histories the most (Druss & von Esenwein, 2006; National Association of State Mental Health Program Directors [NASMHPD] & National Technical Assistance Center [NTAC], 2004; Sanchez, Chapa, Ybarra, & Martinez, 2012). Not only do these groups have higher rates of morbidity and mortality (Parks, Svendsen, Singer, Foti, & Mauer, 2006), they face barriers to accessing care, find that care systems are unresponsive to their particular needs, and may use services differently than recommended (Dichter & Marcus, 2013; Hulme, 2000; Johnson & Zlotnick, 2007; Lee, Ayers, & Kronenfeld, 2009; Sickel, Noll, Moore, Putnam, & Trickett, 2002). Furthermore, many practitioners do not fully understand behavioral health conditions or the impact of trauma. Biases and stereotypes about the nature of these conditions or the people affected by them and their needs can affect the services they receive and their relationship with the healthcare system. To better engage people seeking services with behavioral health conditions and trauma histories, the unique aspects of these conditions must be better accounted for in person-centered approaches to care.

Given the high rate of trauma exposure and behavioral health conditions in the general population, a need for a universal approach to address them exists. While person-centered care provides a foundation, it does not fully account for the specific needs of subgroups or the potential for improving services through practices such as integrating peer support workers into service delivery. Over the past few decades, recovery-oriented approaches and trauma-informed care have emerged to address the needs of people with either behavioral health conditions or trauma histories or both. While these frameworks share many principles of person-centered care, they have been implemented only in select settings, so many hospital-based practitioners may be unfamiliar with them (Buntin et al., 2006; NASMHPD & NTAC, 2004). Although recovery-oriented approaches and trauma-informed care overlap, each framework enriches our understanding of how behavioral health problems contribute to adverse health outcomes.

In June 2015, the BRSS TACS team and SAMHSA convened an Expert Panel to address the growing need to bring the concepts of trauma-informed, person-centered, and recovery-oriented care into healthcare settings. This meeting report summarizes the information and recommendations generated through that Expert Panel.

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2 Recovery-oriented approaches and trauma-informed care are reviewed on pages 11–14.

3 One note about recovery-oriented care versus the recovery-oriented system of care (ROSC) model promoted by the addictions recovery movement to support long-term recovery from substance use disorders: This paper is specifically geared toward supporting discussion of implementation within a care system—a health home or hospital setting—and therefore does not include in-depth discussion of the ROSC framework; the ROSC model includes the complete network of natural and professional relationships that support the long-term recovery of individuals and families nested within larger cultural and community environments (White, 2014).
SUMMARY OF PROCEEDINGS

The Expert Panel brought together a diverse group of hospital administrators; policy makers; healthcare practitioners; people with lived experience of trauma, mental health conditions, and substance use disorders; recovery experts; trauma experts; researchers; and payers of healthcare costs. Panelists represented different geographic areas (urban, suburban, and rural); different professional roles (researchers, people with lived experience, healthcare practitioners, policy makers, and insurers); and different systems and settings (academia, hospitals, integrated care settings, and community health agencies). A roster in Appendix 1 lists Expert Panel participants and facilitators.

These experts participated in a two-day virtual meeting to exchange ideas, discuss challenges, and explore strategies and solutions that would support a universal approach to recovery-oriented care in medical settings. Before convening, panelists received a background paper, *Promoting a Universal Approach to Recovery-oriented, Trauma-informed Care in Hospitals and Medical Home Settings*, which provided background on each of the three frameworks—trauma-informed, person-centered, and recovery-oriented care—and a crosswalk that synthesized common elements and highlighted unique contributions of each. The background paper provides a foundation for this meeting report and is summarized in the following three section: *Describing the Frameworks for Universal Design, The Unique Contributions of Recovery-Oriented and Trauma-Informed Care, and Crosswalk: Principles of Universal Design*.

Purpose and Objectives

The purpose and focus of the Expert Panel was on promoting a universal approach to recovery-oriented care in hospitals and medical homes. The BRSS TACS team asked panelists to address the following objectives:

- To define elements of a recovery-oriented approach to care in hospitals and medical homes settings;
- To identify practices for recovery-oriented care in healthcare settings that are trauma-informed, person-centered, and peer-inclusive;
- To identify opportunities and barriers to implementing recovery-oriented approaches in these healthcare settings; and
- To discuss ideas for developing resources and products, such as a toolkit, that practitioners can use to help implement recovery-oriented approaches in hospitals and medical homes.
The agenda (see Appendix 2) featured formal presentations, plenary discussions, and breakout group discussions with report-back presentations. This format encouraged each panelist to speak on a range of issues and afforded opportunities for focused small group discussions. Appendix 3 lists resources that the panelists considered relevant to the discussion; these were distributed to the panel as background reading in preparation for the meeting.

**Questions Considered by the Expert Panel**

The BRSS TACS team invited panelists to explore specific questions, including:

- How do we move from a theoretical framework (as described in the background paper) to a practical framework that hospitals and medical home settings can readily implement?
- Given that many unique features of both recovery-oriented and trauma-informed care are attitudinal and knowledge-based, how do we operationalize them?
- What practices and guidelines need to be in place before implementing a universal approach?
- What are the opportunities for and barriers to implementing the universal approach in hospitals and medical home settings?
- What organizational buy-in is necessary to foster the implementation?
- What are the regulatory and finance implications?
- What possibilities does the Affordable Care Act provide to implement a universal approach?
- What are training and technical assistance needs?
- What tools and products would be helpful?
- What training and products do medical and behavioral health staff need to understand and support a peer workforce in medical and integrated settings?

As a result, we are able to organize the panel's work into the following major themes:

- Critical Elements of a Universal Design
- Setting the Stage for Implementation of a Universal Design
- Implementation of a Universal Design
  - Awareness of challenges and opportunities
  - Systems change
  - Education and training
- Sustaining Change

This report provides background information on the frameworks panelists reviewed in preparation for their virtual meeting. These frameworks—person-centered, recovery-oriented, and trauma-informed—are then synthesized in a crosswalk. The bulk of the report focuses on how to move from the theoretical to an operational framework. Case studies from two organizations—Southcentral Foundation in Anchorage, Alaska and the Block Center for Integrative Care in Chicago, Illinois—are included to provide practical examples of ways to integrate Universal Design. The report includes these additional background materials:

- Orientation packet (Appendix 5)
- PowerPoint presentation slides (Appendix 6)
- *Opportunities and Challenges Presented by Healthcare Reform* by Robert Sember (Appendix 7)

While not a definitive roadmap, the report is the first step in a larger conversation on how to seize the unique opportunity afforded by the significant redesign of the U.S. healthcare system and be part of healthcare transformation. Adopting a universal approach represents one way the nation's healthcare system could evolve to better support people using services, their families, and communities in achieving and maintaining optimal health and wellness.
DESCRIBING THE FRAMEWORKS FOR UNIVERSAL DESIGN

This section provides background information on person-centered, recovery-oriented, and trauma-informed care; identifies common principles to inform a universal approach specifically addressing the unique needs of persons with behavioral health conditions and trauma histories; and describes the overlapping and unique principles and practices of each framework.

Person-centered Care

Person-centered care is a concept introduced to reduce the burden of illness and improve the quality of life of people suffering from both acute and chronic illnesses. It may have originated from Florence Nightingale’s transformational approach to providing nursing care for the whole person rather than focusing on the disease (Lauver et al., 2002). In the 1940s, the U.S. psychologist Carl Rogers introduced the notion of person-centeredness and holistic care, which focuses on the individual’s strengths, understanding the whole person, and recognizing the person’s abilities to draw on existing resources to overcome difficulties (Rogers, 1961). Balint (1957) pioneered the concept of patient-centered medicine using innovative approaches to improving doctor-patient communication and understanding patients’ unique lives as the pathway to ensuring quality care.

Southcentral Foundation located in Anchorage, Alaska, is committed to ensuring that people have access to care whenever they need it, wherever they need it. This is accomplished through open-access, same-day service in an environment that encourages individual voices at every level.

At Southcentral Foundation, people do not have to wait for appointments or go to different buildings to access different practitioners. Care is provided, when and where requested, by staff who are committed to integrated care in a culturally informed atmosphere.

Owned and operated by people who are Alaska Native, Southcentral Foundation seeks to respect what is important to each person served. People who reflect the demographics of the population served are given preference in hiring. The buildings are constructed in a culturally sensitive way, with floors that are meant to mimic nature, space that encourages gathering and comingling, and “talking rooms,” which are less medical and provide a space for practitioners and people accessing services to have meaningful discussions.

—Shane M. Coleman, MD, MPH
care (Morgan & Yoder, 2012). In the 1970s, the value of patient education, an idea emerging from the self-care movement, contributed to the growing interest in person-centeredness (Bauman, Fardy, & Harris, 2003; McMillan et al., 2013). Central to these changes was the recognition of the relationship between practitioners and people using their services and the need to consider individuals’ experience within the context of their lives (Lipkin, Quill, & Napodano, 1984; Stewart et al., 1995).

The linchpin of person-centered care is the ongoing, mutually respectful, collaborative relationship between the practitioner and the person being served. Practitioners and the people they serve are equal partners, closely collaborating in decision making. The “patient” in a person-centered system is not a passive recipient of expertise nor is the physician the sole authority on the individual’s illness narrative. To emphasize this shift, person-centered care does not use the word patient, but instead employs terms such as person, people accessing services, and people seeking services. The relationship between practitioners and people seeking services builds on a narrative inclusive of the individual’s life context, needs, preferences, priorities, and goals that extends beyond the presenting symptoms. At the same time, practitioners offer their scientific knowledge and understanding.

Within this framework, information is shared and bidirectional, acknowledging the person accessing services as the expert of his/her own circumstances and illness. Once the practitioner and the individual understand the illness in context and clarify the individual’s needs and preferences, they embark on a process of shared decision making informed by scientific evidence (Deegan & Drake, 2006). Practitioners listen empathically, share their expertise and informed opinions, and negotiate service delivery plans with the person accessing services that lead to the best possible health outcomes. Finally, practitioners document these processes as essential parts of the health record. Similar to documenting symptoms, documentation of the person’s goals, needs, and priorities are testament to the significance of a holistic perspective, providing relevant data for evaluating care from the perspective of the one seeking it.

Integrated care systems provide the optimal environment for implementing person-centered care (Epstein et al., 2010). To best respond to the health needs of those seeking services and promote wellness and healthy lifestyles, care must be coordinated among all practitioners serving the individual, preferably in collaborative teams. When systems are integrated, practitioners from different systems can engage in team building and partnering, including sustained collaborations with people accessing services and their families (Johnson et al., 2008).

Epstein and colleagues (2010) use a three-legged stool analogy to describe the elements necessary for implementation:

- Involved, informed, and actively engaged individuals and families (Carman et al., 2013)
- Responsive practitioners
- Well-integrated, interdisciplinary healthcare environments that support this approach

At the center is the sustained, mutually respectful, healing relationship between the practitioner and person accessing services, grounded in trust, bidirectional communication, and respect (Green et al., 2014). When the individual and the practitioner interact as people—in humane ways (Mead & Bower, 2000)—healing is possible. The healing relationship can only thrive when endorsed by organizational infrastructure and supports (e.g., training, health information technology) that foster integrated care, team building, effective communication, access to care, and ongoing quality improvement (Epstein et al., 2010).

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At Southcentral Foundation, people accessing services, called customer-owners, are involved at every stage of decision making. For example, after hearing input that staff badges contained too much information and were confusing to read, the badges were redesigned to include only the staff member’s name and department. The redesign removed titles, credentials, and other text that was making it difficult for some people to read the relevant information. This change reflects staff commitment to a focus on access and the relationship.

—Shane M. Coleman, MD, MPH
Recovery-oriented Care

Mental health and substance use conditions are prevalent in the general U.S. population. Each year, one in five adults in the U.S. experiences a mental illness or substance use disorder (Centers for Disease Control and Prevention [CDC], 2011; Substance Abuse and Mental Health Services Administration [SAMHSA], 2014b). Almost half of all adults will experience a diagnosable mental health condition or substance use disorder in their lifetime (CDC, 2011). Nearly 70 percent of individuals with mental health or substance use conditions have co-occurring physical health conditions (Druss & Walker, 2011), more than half of which go unrecognized (Hogg Foundation for Mental Health, 2008) or untreated due to barriers accessing care and a focus on acute healthcare needs over chronic conditions (Koyanagi, 2004). Left untreated, these physical health conditions may lead to higher rates of premature mortality, resulting in significantly reduced life expectancy for people with serious mental illness and substance use disorders (Parks, Svendsen, Singer, Foti, & Mauer, 2006).

The addiction and mental health recovery movements emerged as strength-based approaches that gave people using services voice in their treatment choices and promoted the idea that recovery was possible. As with person-centered care, differing definitions and principles of recovery have evolved over the years. SAMHSA worked with members of the addiction and mental health recovery communities to develop a definition of recovery from these disorders: “a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential” (SAMHSA, 2012).

One fundamental challenge of implementing person-centered care is the need to reconcile the longstanding medical, disease-based paradigm with the recovery paradigm (Tandora, Pocklington, Gorges, Osher, & Davidson, 2005). Person-centered care is at the heart of the recovery movement (Farkas, Gagne, Anthony, & Chamberlin, 2005; SAMHSA, 2012). Recovery practice empowers people to make informed choices, collaborate with their practitioners in shared decision-making, fully participate in community life, and actively set goals that improve their health outcomes. The President’s New Freedom Commission on Mental Health (U.S. Department of Health and Human Services [USDHHS], 2003) definition highlights the key concept that recovery does not imply a complete amelioration of symptoms, which are one dimension of a person's experience, but not the defining dimension. Recovery is about being able to engage in a full and meaningful life as determined by the individual, regardless of the presence or absence of symptoms:

“Recovery refers to the process in which people are able to live, work, learn, and participate fully in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms” (U.S. Department of Health and Human Services, 2003, p. 5).

While these definitions have been controversial among many in the substance use disorder community who believe that the cessation of substance use (abstinence) is a sine qua non of recovery, attitudes have been shifting. The research and medical communities have long recognized partial recovery and partial remission. From a diagnostic perspective, remission from a substance use disorder includes both abstinence and the reduction of use to levels that do not meet diagnostic criteria for substance use.

In the decade since the Commission report, recovery has grown as a concept and a guiding principle of service delivery. The mental health consumer-survivor movement—which stresses hiring peer support workers (Chamberlain, 1984, 1990; Deegan, 1988, 1996; Fisher, 1994); growth of psychiatric rehabilitation (Anthony, Kennard, O’Brien, & Forbess, 1986; Anthony & Liberman, 1986; Munich & Lang, 1993); and greater understanding of the change process (Prochaska & DiClemente, 1983; Prochaska, DiClemente, & Norcross, 1992)—is central to understanding the critical significance of the recovery concept within mental health. Notably, researchers now acknowledge that mental health recovery is possible and achievable. World Health Organization research across continents found that 28 percent of people with severe mental illness reported complete remission of symptoms and 52 percent reported social recovery. The ability to maintain work, relationships, and a meaningful life with medication or other treatments (Davidson, Harding, & Spaniol, 2005; Hopper, Harrison, Janca, & Sartorius, 2007; Ralph,
boustered the imperative of adopting recovery-oriented principles and establishing recovery-oriented systems of care.

SAMHSA identifies four dimensions of recovery: health, home, purpose, and community (SAMHSA, 2012, p. 6), and summarizes the underlying values and principles of recovery as follows. Recovery...

- Emerges from hope
- Is driven by self-determination and self-direction (e.g., person-driven)
- Occurs via many pathways
- Involves a person holistically: mind, body, spirit, and community
- Is supported by peers and allies
- Is supported through relationships and social networks
- Is culturally based and influenced
- Is supported by addressing trauma
- Involves individual, family, and community strengths and responsibility
- Is based on respect

The emphasis on hope and respect helps individuals with mental health and substance conditions combat prejudice and internalized negative perceptions. The mental health consumer-survivor movement, through sharing lived experiences of prejudice and discrimination, brought attention to the ways in which stereotyping hampered the lives of individuals with behavioral health conditions. These biases and stereotypes reduce access to resources and opportunities, such as housing and employment. When internalized, individuals with lived experience may experience low self-esteem, isolation, and hopelessness (Frese & Davis, 1997).

One of the most important contributions of the mental health recovery movement has been its focus on the essential role of peer support workers in the mental health system. Peers model recovery and provide hope by skillfully using their own lived experience of recovery. Peers may work as part of multidisciplinary care teams or may be in senior decision-making positions. Peer support workers help the team and people accessing services to shift their focus from deficits and illness to strengths, wellness, and recovery.

The inclusion of peers has long been recognized as an essential component of substance use disorder recovery, although efforts to transform substance use disorder care systems to be more recovery-oriented are more recent and have generally received fewer focused resources and attention than those in the mental health system. Additionally, people in recovery have provided services and led agencies for many years. However, they have not functioned or been recognized as peers or people in recovery, but rather as professionals and administrators. Outside of mutual aid programs such as Alcoholics Anonymous, Narcotics Anonymous, or SMART Recovery, viewing peers as essential providers is a relatively recent phenomenon in the modern addiction treatment systems.

Although providers are making progress toward adopting recovery-oriented care principles, implementation in behavioral health and integrated care settings has not been fully realized due to lack of resources, workforce issues, inadequate training, fragmented care, stereotypes about mental illness and addiction, limited adoption of evidence-based practices, and lack of inclusion of people with lived experience in designing and implementing services (Balas & Boren, 2000; Geiger, 2001; Hoge et al., 2013; IOM, 2003; Klein & Hostetter, 2014; Koyanagi, 2004; van Ryn & Burke, 2000).

**Trauma-informed Care**

Trauma is pervasive among adults and children in the United States. A traumatic event is actual or threatened harm to one’s life or sense of integrity or well-being. A national study reported that almost 90 percent of respondents reported at least one traumatic event in their lifetime, with multiple exposures being the norm (Kilpatrick et al., 2013). Approximately 60 percent of children experience at least one traumatic event annually (Finklehor, Turner, Ormrod, & Hamby, 2009). Within systems serving low-income populations (e.g., child welfare and homelessness), traumatic stress may be nearly universal (Bassuk et al., 1996;
Hayes, Zonneville, & Bassuk, 2013). The Adverse Childhood Experiences (ACE) Study documented a significant connection between childhood exposure to trauma and negative adult behavioral and physical health outcomes (Felitti & Anda, 2010; Felitti et al., 1998). These facts constitute a major public health concern. In fact, Anda and his colleagues (2006) argued that childhood trauma is the most significant public health concern in the United States and that chronic exposure to traumatic stress is the norm, not the exception (Cook et al., 2005).

Extensive research has demonstrated the link between chronic traumatization and physical health problems (Friedman & McEwen, 2004; Irish, Kobayashi, & Delahanty, 2010; Neumann, Houskamp, Pollock, & Briere, 1996). A critical review of behavioral and medical health care use by trauma survivors found increased mental health service use among women and individuals diagnosed with posttraumatic stress disorder (Elhai, North, & Frueh, 2005). Research has also examined the effects of certain types of traumatic exposure on healthcare use. For example, women experiencing intimate partner violence are often reluctant to seek help specifically for violence, but use primary care and emergency medical services more frequently than do others free from violence (Dichter & Marcus, 2013; Johnson & Zlotnick, 2007; Plichta, 2004).

Although French neurologist Jean Martin Charcot first explored the impact and devastating consequences of traumatic experiences in the late 1800s (van der Kolk, 2007), the concept of trauma-informed care was only introduced about 25 years ago. Subsequent research demonstrated the necessity of developing a system of care to respond to the specific needs of individuals with trauma histories:

- The ACE Study (CDC, 2014; Felitti & Anda, 2010; Felitti et al., 1998) examined the relationship between childhood maltreatment and health and well-being in adulthood. Between 1995 and 1997, more than 17,000 people participated, sharing valuable information about their experiences of family dysfunction and childhood neglect and abuse. Almost two-thirds of participants reported at least one ACE, with 20 percent of participants reporting three or more ACE (Felitti et al., 1998).

- Evidence from the more than 50 studies that emerged from the original ACE Study shows clear relationships between adverse childhood experiences and (a) social, emotional, and cognitive impairment; (b) health-risk behaviors; (c) disease, disability, and social difficulties; and (d) premature death. Several studies have replicated these findings, including a 2009 CDC study with more than 26,000 participants across five states and a Texas study with more than 5,300 participants (Dube, Cook, & Edwards, 2010).

- The Women, Co-occurring Disorders, and Violence Study (SAMHSA, 2007) was a five-year, multisite demonstration project that examined the lack of responsive services for women with trauma histories (Huntington, Moses, & Veysey, 2005). The study concluded that:
  - services must be trauma-informed;
  - women with lived experience should be included in service development and provision;
  - services must be integrated to meet the needs of people seeking services; and
  - comprehensive, gender-specific services must be available.

Trauma-informed care, also based on person-centered principles, has emerged as a

“... strengths-based framework grounded in an understanding of and responsiveness to the impact of trauma. It emphasizes physical, psychological, and emotional safety for both practitioners and survivors, and creates opportunities for survivors to rebuild a sense of control and empowerment” (Hopper, Bassuk, & Olivet, 2010, p. 82).

Organizations and practitioners directly integrate their knowledge and understanding of trauma into everyday practice and promote their capacity to recognize and respond to the needs of trauma survivors. Trauma-informed care implies that recovery is possible for everyone, regardless of how vulnerable they may appear. Organizations seeking to implement trauma-informed care must consider how well they have integrated its principles by focusing on ongoing training priorities, relationship building, physical environment, service delivery, and policies and procedures at all levels of the organization (Center for Social Innovation [C4], 2015).
SAMHSA described various foundational assumptions underlying a trauma-informed approach:

“A program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices; and seeks to actively resist re-traumatization” (SAMHSA, 2014c, p. 9).

SAMHSA’s Treatment Improvement Protocol on Trauma-Informed Care in Behavioral Health Services (SAMHSA, 2014a) lists a range of strategies for evaluating the degree to which an organization is trauma-informed. These include committing to principles of trauma-informed care, using these principles in strategic planning, creating a trauma-informed oversight committee, conducting organizational self-assessment, developing an implementation plan, incorporating universal routine screenings, using science-based knowledge, increasing safety, and creating a peer-support environment. Foundational assumptions underlying trauma-informed organizations include:

- Safety
- Trustworthiness and transparency
- Peer support
- Collaboration and mutuality
- Empowerment, voice, and choice
- Cultural, historical, and gender issues (SAMHSA, 2014a)

When organizations embrace these principles, they are able to provide care that is more sensitive to the needs of individuals who have experienced trauma. Additionally, when programs and staff understand the dynamics and consequences of traumatic experiences, they are able to understand behaviors as adaptive rather than pathological (Elliott, Bjelajac, Fallot, Markoff, & Reed, 2005). Further, trauma-informed systems embrace and promote recovery. Trauma can leave people feeling shattered and broken. Systems that are deficit-oriented rather than strengths-based tend to impede the healing process. Trauma-informed systems operate with the belief that all people can achieve meaningful, purposeful, fulfilling lives. Systems of care can inadvertently retraumatize people through routine procedures and policies. Retraumatization occurs when an environmental cue related to trauma triggers a psychological or physiological response. Systems that are trauma-informed work to minimize triggers and are responsive when people accessing services have been triggered.

Harris and Fallot (2001) emphasized that integrated care is essential for providing person-centered, holistic care that attends to all the needs a person seeking services may express. Trauma can affect every domain of an individual’s life. Integrated care can help individuals with trauma histories avoid having to navigate multiple systems. Incorporating peers in service delivery is an essential aspect of care, but trauma-informed systems need to bring people with lived experience into the organizational structure and leadership as well (Guarino, Soares, Konnath, Clervil, & Bassuk, 2009). Trauma-informed systems also pay attention to the impact on practitioners of working with individuals who have experienced trauma. Understanding secondary traumatization and creating a culture that promotes self-care are essential components of a trauma-informed organization (C4, 2015).
THE UNIQUE CONTRIBUTIONS OF RECOVERY-ORIENTED AND TRAUMA-INFORMED CARE

The principles of person-centered care form the foundation of recovery-oriented care and trauma-informed care. In addition to incorporating these principles and practices, recovery-oriented and trauma-informed frameworks offer additional strategies for addressing the needs of individuals with behavioral health conditions and those with trauma histories. Expanding person-centered care to include principles and practices of recovery-oriented and trauma-informed care may help us develop a universal design for providing high-quality care to those with behavioral health conditions and trauma exposure. Based on the literature review summarized above, we developed a crosswalk that highlights the unique features of each of these two frameworks. We describe these unique elements below.

**Principles of Recovery-oriented Care**

Recovery-oriented care brings various unique principles and practices to service delivery, including:

- knowledge about mental health and substance use conditions and their relationship to medical conditions;
- familiarity with local resources and mechanisms for helping people access them;
- sensitivity to the impact of negative attitudes and beliefs about people with behavioral health conditions;
- inclusion of peers as essential healthcare practitioners and members of multidisciplinary teams and in the design, implementation, and evaluation of services;
- recognition that many pathways to recovery exist and that both professionals and peers must develop the knowledge and skills to help individuals find and follow the pathway that works best for them, regardless of the practitioner's familiarity or comfort level with that pathway;
- the belief that recovery is possible and achievable for all individuals; and
- the relationship between a practitioner and the person seeking services is a collaboration geared toward helping people seeking services achieve their goals.
Understand the relationship between behavioral health and medical conditions. Behavioral and physical health are inextricably linked. The relationship is complex and bidirectional with shared risk factors (Katon, 2003). Having a mental health or substance use condition is a risk factor for developing medical disorders and vice versa (Carney & Jones, 2006; Carney, Jones, & Woolson, 2006; Egede, 2007). People with behavioral health conditions are at high risk of developing various co-occurring chronic medical conditions, including diabetes, infectious disease, respiratory disease, obesity, asthma, arthritis, epilepsy, cancer, HIV/AIDS, sexually transmitted infections, injury, gastrointestinal problems, and cardiovascular disease (CDC, 2011; De Alba, Samet, & Saitz, 2004; Hogg Foundation for Mental Health, 2008; Jones et al., 2004; Koyanagi, 2004). Additionally, people with behavioral health conditions use tobacco at twice the rate of the overall population (Lasser et al., 2000). Furthermore, chronic stress, adverse health behaviors, socioeconomic factors, and adverse childhood experiences are shared risk factors for poor behavioral and medical health (Katon, 2003).

Know that recovery is possible and achievable for everyone, regardless of vulnerability. One of the hallmarks of the movement toward recovery-oriented systems and services for those with mental health and substance use disorders was the shift from an acute care to a chronic care model. In an acute care model, practitioners attend to alleviating immediate symptoms, such as helping someone safely withdraw from opiates or alcohol. Practitioners pay insufficient attention to developing the person’s coping skills and social supports needed to sustain long-term recovery in the community. Discharge planning is often limited to a recommendation to attend mutual aid meetings and does not adequately account for the fact that the individual with a substance use disorder may be returning to the environment where he or she has used substances in the past.

In a recovery model, the attention shifts to identifying and building on strengths, often described as recovery capital: “the breadth and depth of internal and external resources that can be drawn upon to initiate and sustain recovery from severe AOD problems” (White & Cloud, 2008, p. 22). In a recovery-oriented approach, both treatment professionals and peer support workers collaborate with people seeking services to build recovery capital (Cloud & Granfield, 2004; Granfield & Cloud, 1999; White & Cloud, 2008). The focus is on building health, wellness, and a productive and engaged life; the illness is only one dimension of the experience and not the center of an individual’s life. The illness is something that one can manage or recover from.

Understand that many pathways lead to recovery. Practitioners adopting a recovery-oriented approach recognize that each individual brings a unique narrative that encompasses his or her experience of disease and perspective about the possibility of recovery. Practitioners assist individuals seeking recovery to craft new chapters in their narrative that transcend and give meaning to events in the past—no

The Block Center for Integrative Cancer Treatment uses an integrative approach to provide comprehensive care, allowing it to treat all aspects of well-being.

The team aspect is prevalent in the care provided and in the organizational culture. The team of practitioners includes medical staff, dietitians, physical therapists, and biobehavioral medicine staff and each member is integral to the whole. There is strong communication among members, who use weekly team meetings, electronic medical records, and regular emails, and lunch together whenever possible.

Our practice consists in great part of individuals who have advanced cancer, and many of them have already undergone significant medical treatment. The Block Center provides person-centered care, and the treatment goals, values, and concerns of people using our services are recorded in the medical record and discussed during medical visits. Treatment protocols are frequently adapted to address the specialized needs and reflect the values of those accessing our services.

The Block Center also recognizes the importance of support networks, encouraging people seeking care to bring family or friends to appointments, both to help absorb the large amount of information presented and to offer needed support.

Another key characteristic of the organizational culture is that staff work from the same model—the program for fighting cancer that Keith Block, MD, presented in his book, Life Over Cancer. Having this one reference point helps practitioners see themselves and their practices within the context of the whole individual.

—Charlotte Gyllenhaal, PhD
matter how painful these events may have been. The narrative individuals bring to services and take with them afterward reflects their preferences, struggles, strengths, culture, and background. Just as this narrative shaped their pathway to recovery, so it will shape their recovery pathway. Supporting an individual requires understanding and appreciating his/her narrative, needs and preferences, finding treatments and supports with the best fit, and helping the individual develop the recovery capital needed to create and sustain new chapters in their narrative. The pathways to recovery are not linear. Individuals will experience setbacks, periods of growth, and plateaus. Symptoms can recur, just as they do with other chronic conditions such as asthma or diabetes. Sometimes the recurrences are predictable and sometimes not. The key to building health and wellness is building the capacity to change habits and patterns, and to learn new routines, such as taking medication regularly and seeking social support (e.g., through mutual aid). Additionally, when practitioners adopt a recovery-oriented approach, they do not view a recurrence of symptoms as an individual failing, but rather as an opportunity for learning, growth, and consolidation of recovery. Fostering and encouraging resilience is an essential part of sustaining recovery through all its stages.

Address misunderstanding and discrimination associated with behavioral health conditions. Fear, misunderstanding, and the social exclusion and discrimination they can engender create significant barriers to recovery. These barriers are reflected in the negative attitudes held by the general public about people with behavioral health conditions and internalized by people with these conditions—an experience sometimes referred to as “internalized oppression.” Negative attitudes can result in unequal access to resources needed for functioning, such as housing, education, employment, relationships, and health care (Corrigan, Markowitz, & Watson, 2004; Link & Phelan, 2001). Additionally, such attitudes can lead to punitive policies and practices that sometimes are enshrined in law. When someone with a behavioral health condition internalizes experiences of discrimination and begins to believe them, they may be reluctant to disclose their conditions, which can interfere with treatment and, when necessary, reasonable accommodations (Greene-Shortridge, Britt, & Castro, 2007; Nadeem et al., 2007; USDHHS, 1999, 2001). Recovery-oriented care requires that practitioners be aware of the potential impact of fear, misunderstanding, and discrimination—not only on people seeking services, but on all systems and individuals with whom the people seeking services interact. Recovery-oriented frameworks bring attention to how these attitudes shape opportunities for people with behavioral health conditions. Understanding the nature of mental health and substance use conditions and the multiple pathways to recovery helps reduce misconceptions and biases. Additionally, a recovery-oriented perspective recognizes the subtle power of the language we use to influence our perception of and response to individuals with behavioral health conditions, even among mental health and substance use disorder professionals (Kelly & Westerhof, 2010).

Include peer support workers in all aspects of recovery-oriented care. Peer support workers are individuals with behavioral health conditions who are trained to help others by instilling hope and working toward recovery goals. They are the cornerstone of recovery-oriented care. A peer workforce operates from a strengths-based, person-centered framework, building continuous healing relationships with people seeking services and their families to facilitate recovery (Zubko, 2012). They reflect the individuals they serve, sharing common experiences and providing supportive relationship and a sense of belonging. Their very presence demonstrates to those early, or at critical junctures, in their own journey that recovery is possible and achievable. Additionally, peer support workers remind other practitioners of the hope reflected by a recovery-orientation. The peer workforce serves many roles within integrated care systems, such as decision makers or staff to bridge the gap between traditional practitioners and people using services. Peer support workers can serve as navigators and advocates, helping individuals connect with services in what can be confusing and intimidating care systems. When the peer workforce and people using services are members of the same community, peer support workers can serve as cultural brokers between people using services and practitioners and systems.
Principles of Trauma-informed Care

Although trauma-informed care is a newer framework, its application is crucial to providing responsive care for those who have experienced trauma. The following principles of trauma-informed care extend person-centered principles to be inclusive of individuals with trauma histories.

Provide trauma-informed care at all levels of the organization. To ensure the provision of trauma-informed care, an organization should base its programs and policies on trauma-informed principles. All members of an organization—including people using services—need clear information about the nature of trauma and its profound, often lifelong impact (Hopper, Bassuk, & Olivet, 2010). In addition to understanding trauma, an organization needs written procedures and policies for both staff and individuals accessing services that delineate how they implement trauma-informed principles throughout the organization (Elliott, Bjelajac, Fallot, Markoff, & Reed, 2005). None of these policies should be coercive, and they should be culturally informed (Sokoloff & Dupont, 2005; SAMHSA, 2014a). To ensure that information about people using services’ experiences and circumstances remains private and confidential, an organization should develop clear guidelines about staff communication in common spaces and with other practitioners (Hopper, Bassuk, & Olivet, 2010).

In a trauma-informed organization, people accessing services are involved in reviewing, developing, and adapting policies and procedures (Blanch, Filson, Penney, & Cave, 2012; Guarino, Soares, Konnath, Clervil, & Bassuk, 2009; SAMHSA, 2014a). When organizations develop written policies that support knowledge and skill building among all administrators, staff, and people seeking services, they best ensure commitment to trauma-informed principles. The organization can accomplish this by providing its workforce with ongoing training and technical assistance on trauma and strategies for translating knowledge into skills. Whenever possible, training should be based on adult learning principles, and should be ongoing, experiential, and interactive (C4, 2015).

Understand trauma and its impacts—including its neurobiology. Scientific understanding of the neurobiology of trauma has increased dramatically in the past two decades. The ACE Study and its findings on the prevalence and health risks of childhood trauma raised awareness of both the magnitude and reach of trauma, and its impact on health (CDC, 2014; Felitti & Anda, 2010; Felitti et al., 1998). Practitioners must be aware of the high rates of trauma in the general population and its widespread impact on health, as well as the ways in which trauma can influence relationships with others and systems of care (Hopper, Bassuk, & Olivet, 2010). Without understanding trauma’s influence on relationships and its effect on a person’s worldview, practitioners may misinterpret the individual’s behaviors and inadvertently discourage them from engaging in or continuing treatment. Many individuals with trauma histories have difficulty trusting others. They may be suspicious about therapy, medications and side effects, and engaging with supports. When practitioners understand this and take the time to answer questions and provide reassurance, it can increase the engagement of people seeking services (Blanch, Filson, Penney, & Cave, 2012).

Ensure physical and emotional safety. Many people who have experienced trauma have lost their sense of control, which leaves them feeling the world is unsafe and unpredictable. Trauma-informed care pays close attention to the emotional and physical safety of people accessing services within the healthcare setting. This includes ensuring that the physical space is as welcoming and safe as possible, parking lots and garages are well-lit, waiting rooms are quiet and not overly crowded, and exits to exam rooms are visible and accessible for those using services (Guarino, Soares, Konnath, Clervil, & Bassuk, 2009; Hopper, Bassuk, & Olivet, 2010). Staff and practitioners must also pay attention to emotional safety (Wilson, Fauci, & Goodman, 2015). Are people using your services able to refuse procedures that make them uncomfortable? Can they request that a friend or family member accompany them for sensitive procedures or exams? If a female practitioner is unavailable for gynecological procedures, are female chaperones available? When practitioners understand how trauma changes an individual’s experience and then adopt trauma-informed principles, it helps them realize how interactions and procedures may feel from the perspective of those they serve (Elliott, Bjelajac, Fallot, Markoff, & Reed, 2005).
Include the voice of trauma survivors at all levels of care. A trauma-informed organization should encourage people who access their services or formerly accessed their services to participate within all levels of the organization (Guarino, Soares, Konnath, Clervil, & Bassuk, 2009; Hopper, Bassuk, & Olivet, 2010). These individuals should be included as team members throughout the organization. Their views about safety, addressing crises, treatment or service planning, and referrals should be respected, actively solicited, and form the basis for collaborative decision making (Wilson, Fauci, & Goodman, 2015). This approach maximizes power sharing and governance among practitioners and the people using services. Encourage people being served to voice their opinions and perspectives, and speak up about their organizational concerns. Formal grievance processes should be in place that are confidential and without adverse consequences. When peer support services are available, people accessing services are more likely to have their needs met. Peer support workers can help with orientation, provide direct services, co-lead groups, occupy leadership positions, and be involved in designing and implementing training about trauma-informed care (SAMHSA, 2014a).

Avoid retraumatization. Individuals who have experienced trauma describe healthcare visits as potentially retraumatizing (Davis & Maul, 2015). When a traumatic event reminds an individual through a sensate experience or other cues, such as anniversary dates, retraumatization occurs. When someone is reminded in this way, they may re-experience the trauma through a flashback or dissociative episode, or they may experience emotions similar to those they felt during the trauma, causing them to freeze or flee, thus avoiding needed care. Trauma-informed healthcare systems must avoid retraumatization. Clear, open communication can avoid secrecy, which can be retraumatizing for individuals who have experienced interpersonal traumas, as secrecy is often part of this type of abuse. Using a strengths-based approach and actively listening to people you serve can counter the disbelief and denial they may have experienced (Wilson, Fauci, & Goodman, 2015). Understanding these experiences may help practitioners alter the environment to reduce the likelihood of triggering people using services. Having predictable and public routines and guidelines is also helpful (Guarino, Soares, Konnath, Clervil, & Bassuk, 2009; Hopper, Bassuk, & Olivet, 2010).

Understand and acknowledge secondary trauma. Trauma-informed care recognizes that given the pervasiveness of trauma, many staff have personal experience with trauma (Guarino, Soares, Konnath, Clervil, & Bassuk, 2009). Working with people who have experienced trauma can take a tremendous toll on practitioners (Hernandez, Engstrom, & Gangsei, 2010). Trauma-informed care emphasizes the organizational imperative to understand and acknowledge secondary trauma among practitioners. Trauma-informed healthcare organizations train all staff to understand secondary stress, acknowledge their experiences, and prioritize and implement self-care practices. Additionally, organizations apply trauma-informed principles within their culture and structure to ensure safety within professional relationships.
CROSSWALK: PRINCIPLES OF A UNIVERSAL DESIGN

The graphic below integrates the principles of person-centered, recovery-oriented, and trauma-informed care to present a universal design (see figure 1). Person-centered principles provide the foundation, while recovery-oriented and trauma-informed principles extend the framework to best meet the needs of nearly everyone seeking services.

Figure 1. Universal design

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FROM THEORETICAL CONCEPTS TO OPERATIONAL FRAMEWORK: WORK OF THE EXPERT PANEL

Behavioral health settings have made considerable progress in achieving person-centered care by implementing recovery-oriented and trauma-informed care. However, an integrated, universal approach addressing the unique needs of individuals with behavioral health conditions and trauma histories has yet to be developed for other practice settings. This will necessitate bringing clarity to what constitutes care from both a process perspective (i.e., how to engage in roles, relationships, and planning) and documentation perspective (i.e., how a written plan reflects this process, which respects the individual and satisfies fiscal and regulatory requirements) (Bedregal, O’Connell, & Davidson, 2006; C4, 2015).

Following its deliberations, the Expert Panel was able to offer recommendations and suggest an initial plan for moving from the theoretical concept of Universal Design to concrete steps toward systems change. We have organized the panel’s work into the following themes.

◆ Critical Elements of a Universal Design
◆ Setting the Stage for Implementation of a Universal Design
◆ Implementation of a Universal Design
  — Awareness of challenges and opportunities
  — Systems change
  — Education and training
◆ Sustaining Change

The report concludes with suggestions for next steps and moving forward.
THEME ONE: CRITICAL ELEMENTS OF A UNIVERSAL DESIGN

Originating in architecture and product development (Rose & Meyer, 2002), universal design calls for designs that the greatest number of people can use to the greatest extent possible without modification. Rose and Meyer applied this approach to education in the 1990s (Meyer, Rose, & Gordon, 2014). Through the work of this Expert Panel, we are promoting this concept within healthcare systems. As with architecture and learning, a universal design for healthcare delivery should provide quality care to the greatest number of people without modification. By synthesizing the principles of person-centered, recovery-oriented, and trauma-informed care, healthcare providers can offer services that meet the needs of the greatest number of individuals, including those most marginalized by traditional healthcare delivery (Druss & von Esenwein, 2006; NASMHPD & NTAC, 2004; Sanchez, Chapa, Ybarra, & Martinez, 2012).

Panelists considered the critical elements that must be included within a universal design. These 10 principles received the most support from panelists:

- Training
  - Across all personnel, including administrators and leadership, practitioners, support staff
  - People accessing services, family members, community partners
- Organizational buy-in
- Organizational/institutional culture
- Interdisciplinary care teams
- Therapeutic alliances/relationships among practitioners, care teams, people accessing services, and their family members
- Peer integration across all levels of the organization
- Consideration of incentives
- Self-care integration
- Tools to do the work
- Connection between hospital and community
Panelists agreed that **training for all** healthcare staff and people using services, their family members, and community partners was an essential component of universal design. As the science of behavioral healthcare provision and the ways in which trauma influences the brain and body are continually evolving, ensuring mechanisms to allow for ongoing learning is critical to the success of universal design.

Training can help to ensure and support **organizational buy-in**. While administrative and leadership buy-in is essential for effective implementation and spread of universal design, the majority of staff will also need to support this framework. Closely related to organizational buy-in is the awareness of and attention to **organizational/institutional culture**. Universal design is largely an attitudinal shift grounded in an understanding of the impact of behavioral health conditions and traumatic experiences. It thus often requires a shift in the organizational culture.

Successfully implementing universal design requires practitioners across medical and behavioral health care to work together in coordinated **interdisciplinary care teams**. When practitioners collaborate in care teams, it ensures that the team treats people using their services as whole people without fragmenting behavioral and medical health care.

Built on person-centered care, universal design places the **relationship between the practitioner and the person using services** at the center of all care. Attention and support for developing safe, trusting, healing relationships among practitioners, care teams, people accessing services and their families, and support people are critical to universal design.

**Peer support workers** are key members of interdisciplinary care teams and across all organizational levels. Panelists highlighted the importance of integrating peers at every level of the organization. The peer workforce can fill many different roles throughout the healthcare system and form bridges among healthcare provider systems and practitioners, people accessing services and their families, communities and community organizations.

Panelists, particularly those working in healthcare systems, highlighted the realities of **incentives** in driving healthcare practices. In particular, they noted the role of the Affordable Care Act in providing incentives and disincentives for physicians and other practitioners to provide the best possible care for each individual. Achieving greater understanding of how these incentives can support universal design is critical to moving forward.

Several panelists expressed that the background paper did not focus enough on the role of practitioners and their unique position to forward a service-delivery framework that is inclusive of individuals with behavioral health conditions and trauma histories. Panelists also noted the importance of integrating **self-care** practices throughout healthcare systems.

Panelists highlighted the need for practitioners to have the necessary **tools to do the work of universal design**. These might include electronic health records, which can facilitate communication across integrated care teams, screening and assessment measures that are trauma-informed and wellness-focused, and tools that support shared decision making.

Finally, panelists agreed that universal design must emphasize and strengthen the **connection between healthcare systems and the communities they serve**. To forward and support well-being and healthy lives from a whole-person perspective, healthcare systems must become more integrated into the communities they serve. This includes building and maintaining strong connections with community organizations and employing people from the communities served.
THEME TWO: SETTING THE STAGE FOR IMPLEMENTATION OF A UNIVERSAL DESIGN

As described above, the current healthcare system does not meet the needs of those most needing services: individuals with behavioral health conditions and trauma histories. The task of creating a framework that can effectively and efficiently address the needs of these individuals and their families is not without significant challenges. A necessary first step is ensuring that healthcare systems are primed for implementation.

Panelists reflected that great diversity exists among healthcare systems and their extent of adoption of any of the three frameworks. Panelists discussed what organizations should take into consideration to ensure that they were in an optimal position to adopt universal design.

The first consideration is assessing organizational readiness for change. As panelists pointed out, certain healthcare experiences can be more traumatizing than helpful, more triggering than caring. Organizational culture is embedded in policies and procedures, many of which were developed decades ago. Furthermore, staff and practitioners have their own deep-rooted beliefs and professional identities. While some systems are humane and integrated in their approach to care, many are not. Assessing and understanding the receptivity for change within an organization is a key element for making any change.

The second consideration is ensuring organizational buy-in. Achieving universal design requires that leadership, administration, practitioners, and staff at every level be involved and on board. Panelists suggested that organizations develop targeted engagement plans for leadership, administration, healthcare practitioners, insurers, peer support workers, and people using services and their families. They noted specific considerations for each group:

- **Healthcare Administrators**: Administrators are crucial for ensuring effective implementation of universal design, as they make decisions about system structure and how practitioners deliver care. For administrators to commit to a universal design concept, evidence of its impact on outcomes that matter to administrators, such as readmission rates and length of stay, should be provided.
Practitioners: Practitioners are generally overburdened with administrative and clinical responsibilities. Universal design will be effective only if practitioners are able to see benefits in outcomes among the people they serve or a reduction in administrative duties. An incentive structure for practitioners could also reinforce universal design.

Leadership: Ensuring buy-in across all areas of leadership within the healthcare system is essential for successful implementation. Again, the message must specifically target each discipline or department.

Insurers: If insurance companies and Medicaid/Medicare are not at the table, universal design will struggle to move beyond the theoretical stage. Buy-in will require evidence of cost-effectiveness, which may be hard to show initially.

Peer support workers: When organizations have integrated peers throughout the organization, they can be ambassadors for universal design, provided they understand and see the benefits.

People accessing services: Shifting to a universal design will require educating people using services and their families about the changes in healthcare delivery.

The third consideration is **providing financial rationales**. Passage of the Affordable Care Act has resulted in far-reaching changes to how health care in the U.S. is funded, structured, delivered, and evaluated. Some examples include:

- Testing new models of service delivery such as Accountable Care Organizations and Medical Homes
- Reforming provider payment structures such as moving to a reimbursement system based on *value of care over volume of provided services*
- New resources to fund public- and private-sector innovation such as the Patient-Centered Outcomes Research Institute and the Center for Medicaid and Medicare Innovation

Although many aspects drive the financial considerations, panelists generally acknowledge the need for a convincing cost-savings argument as part of any initial dialogue with leadership and administration. Appendix 6 illustrates both the opportunities and challenges for using health reform processes that advance person-centered care.
THEME THREE: IMPLEMENTATION OF A UNIVERSAL DESIGN

Much of the panel discussion focused on how practitioners could implement a universal design framework. Specifically, panelists considered the challenges and opportunities practitioners and organizations would face in implementation, the critical role of systems change and the elements necessary to move that forward, providing ongoing education and training for all staff, and considering and ensuring sustainability.

Challenges and opportunities

Changing systems and practice is a significant undertaking. To prevent barriers from impeding progress, organizations need to identify the potential roadblocks across the organization and map out a plan to address predicted and unforeseen barriers. Similarly, organizations should take advantage of opportunities to support systems change. Identifying departments that have embraced change in the past and finding champions within key areas are just some of the ways in which organizations can begin to identify the areas of opportunity and support for change.

Challenges

Panelists mention several challenges that would hold across medical settings. Specifically, they noted the importance of financial challenges, the culture of medicine, staffing and workforce-related issues, and lack of research metrics to support this change. Many of the challenges are financial in nature having to do with current payment structures for reimbursement, Medicare/Medicaid programs, and other insurance company obstacles to person-centered care. While expectations and demands on practitioners’ time are high, reimbursement structures do not support these expectations. The compensation structure needs to change to support practitioner behavioral change. We describe several complicated challenges below that go beyond the fiscal considerations.

Medical care has its own unique culture. While this culture has many strengths, panelists focused on the aspects that could pose potential challenges in implementation of a universal design.
Typically organized around a set hierarchy, medical culture defines its leadership by academic degrees and expertise. This hierarchy often dictates how to receive and value input. Additionally, the hierarchal nature of medical culture has limited the availability and transparency of information across disciplines and with people using services. When endorsed, these values present a potential conflict with universal design. Specifically, the integration of peer support workers throughout the organization and the emphasis on transparency and mutuality as key components of healing relationships are in opposition to hierarchical systems of power.

Medical systems arguably are designed to minimize staff inconvenience and liability. Universal design asks the system to flip this model and prioritize the needs of the people seeking services, presenting another potential challenge.

Panelists noted that medical practitioners do not have the time or sometimes, interest, to understand the unique needs of the person using services and develop an individualized treatment plan. This has lead to mistrust among people using services and their family and friends. Healing relationships and involving family and other support people require a foundation of trust.

Similarly, some panelists noted that physicians might not be trained to show empathy toward the people they serve. Asking physicians to incorporate a greater understanding of and compassion toward the people they serve may be harder for some than others.

Practitioners may be used to following strict protocols in practice. Universal design requires a nuanced practice, tailored to individuals based on their unique needs, preferences, and goals.

While none of these challenges is insurmountable, healthcare systems must take care to incorporate an understanding of medical culture when developing implementation strategies.

Panelists also noted that issues related to the medical workforce at large were important to consider. In particular, panelists noted the general shortage in certain fields within medical care and the growing expectations and demands on practitioners’ time.

An increase in medical specialization and the shortage of primary care practitioners and other essential medical staff already stress the healthcare workforce. Requiring a paradigm shift within an already burdened system is a challenging request.

Fewer medical students are becoming psychiatrists and family practitioners are the most common prescribers of psychiatric medications.

Organizations need to support healthy work environments, which include adequate supervision and attention to self-care.

Ensuring that the workforce is fully staffed with adequate support is crucial to the success of any implementation effort.

More than at any other point in history, evidence and evaluation data drive today’s clinical care. While research can provide invaluable information on treatment efficacy, many aspects of universal design, such as the centrality of the healing relationship, are not as easily captured through traditional research metrics. Additionally, deep and thorough ways of measuring and evaluating the satisfaction levels of people using healthcare services remain lacking. These data are needed both to determine the most effective ways to move forward and as evidence for practitioners that changes are needed.

Awareness of potential challenges is vital to successful implementation. Organizations can build responses to challenges into implementation planning. Additionally, organizations should be aware of the potential opportunities on which they can build as implementation moves forward. The next section examines opportunities identified by panelists.

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One major issue is not the system, the procedures, or how knowledgeable a physician is about trauma-informed care; many practitioners are in over their heads. They do not want to hear about trauma; it is not that they do not care about the person. Rather, they do not know what to do about trauma. They do not want responsibility in addition to the other things they must do.

They need to understand why an individual may say, “I am a trauma survivor” or “I have had really difficult experiences” and “that may be part of why I am reacting the way I am.” It is important for physicians to understand the origins of comments such as these and what they may mean.

—Julian Ford, PhD
Opportunities

Panelists raised two areas on which organizations could capitalize as they move forward with implementing a universal design. These included identifying departments that have embraced change in the past and finding champions within key areas. Healthcare organizations frequently have to implement new changes in policies and procedures. Drawing on institutional knowledge to identify departments that have demonstrated success in implementing change in the past can help to prepare the organization for universal design. These early adopters can both provide insight on the process of change as well as potentially serve as a pilot department for universal design implementation.

**Identification of champions** throughout the healthcare organization is essential to moving implementation forward. Consider that champions may include community stakeholders, people who use services, and family and friends of people using services in addition to healthcare practitioners and staff. Champions can help to promote universal design and encourage frequent, ongoing staff communication about the implementation process. Champions are key to fostering widespread support, thereby easing integration of universal design (Hernandez, Conrad, Marcus-Smith, Reed, & Watts, 2013; Weiner, 2009).

Systems Change

More than practice guidelines, universal design represents a fundamental shift in the way care is understood, delivered, and received. This attitudinal shift will require that healthcare systems and organizations change from the individual interactions between staff and people seeking services to the policies and procedures that govern the organization. Recognizing the enormity of this task, panel members highlighted a number of significant aspects that changing healthcare systems should consider when implementing universal design. These factors included examining ways in which the Affordable Care Act could be a conduit to change, expanding the framework of the care system beyond the walls of hospitals and clinics, and emphasizing integration as a mechanism to focus on whole wellness.

**The Affordable Care Act** has the potential to support implementation of universal design in healthcare. The emphasis on collaborative care, enhancing health outcomes, and recognition of social and economic disparities and their impact on health care are but a few of the ways that the Affordable Care Act aligns with universal design.

- The Affordable Care Act emphasizes provision of optimal care through shared decision making and integration of medical and behavioral care. Insurers and healthcare administrators have used practitioner incentives and disincentives to encourage this optimal care.
- Recognition of health disparities and encouragement of enrolling low-income individuals and families is one way in which the Affordable Care Act seeks to equalize care provision. Given that individuals and families who are living in poverty or facing health disparities are much more likely to have experienced mental health or substance use conditions and have trauma histories, universal design can help in increasing retention rates for those who enroll (Druss & von Esenwein, 2006; NASMHPD & NTAC, 2004; Sanchez, Chapa, Ybarra, & Martinez, 2012).
- Although empirical data are yet to be collected, given the evidence supporting the three frameworks that form the basis for universal design, it is likely that provision of care under a universal design will improve health outcomes. The Affordable Care Act emphasizes the importance of improved health outcomes as one evaluative metric.

Panelists noted that one major change for healthcare systems was the focus on extending the system of care beyond the medical home within the hospital or clinic walls to include the **medical or health neighborhood**, which would be inclusive of community organizations. They suggested that SAMHSA’s recovery domains of health, home, community, and purpose could serve as the blueprint for wellness (SAMHSA, 2012). This expansion would include careful attention to communication among all agencies working to support an individual in their wellness goals and active development and maintenance of connections among healthcare organizations, community organizations, education systems, and any other system that supports individuals in working toward their wellness goals.
Key to effective change within systems is integration. Integration is required in many areas throughout healthcare systems. Integration is required across disciplines—both broadly between medical and behavioral health and at the discipline level among nursing, medicine, psychology, social work, psychiatry, addiction specialists, and peers. Additionally, the organization must integrate universal design at every level from the leadership to direct service practitioners to people using services. Another facet of universal design is the importance of integrating peer support workers in every level of the organization.

Changing a system is challenging work that requires significant resource and time commitments. To ease the process, panelists further recommended not only drawing from the literature on systems change, but identifying programs or organizations that have already gone through systems change and learning from these sites directly.

**Education and Training**

To successfully implement universal design across a healthcare system, organizations must be willing to make a substantial investment in ongoing education, training, and technical assistance to support staff and practitioners in the transformation. Panelists emphasized the importance of recognizing that in addition to initial investment in training, this work is not a layering on of more information, but rather reconceiving of both what people need to know to do their jobs well and who needs this information. Because universal design highlights the importance of every interaction that people using services have within their healthcare visits, training broadens to include everyone who meets people using services from front desk staff to hospital leadership and administration. The content of training will include basic understanding of behavioral health conditions and trauma and its impact on the brain, body, and overall functioning. Additionally, training will outline the principles and implementation of universal design.

Training will be delivered not only through traditional methods such as education, in-service training, and self-paced, online learning modules, but also training for human resources professionals on hiring practices and expansion of administrative and clinical supervision to support implementation and maintenance of universal design across the organization.

People using services and their support networks as well as community partners should also receive education on health conditions, including behavioral health, the effects of trauma, and what to expect from universal design. Seminars, pamphlets, or online patient portals, when available, could provide education.

Panelists highlighted the importance of providing education tailored to the specific audience. Some suggested grouping education according to staff role, while others argued that this would not align with the goal of integration. Regardless of how trainers group trainees, they should convey the material with sensitivity to the particular audience. As part of this consideration, panelists noted trainers should consider three audiences across professions and groupings and that training should ideally reach all three: the willing, the reluctant, and the uninterested.

Finally, panelists noted the importance of educating and responding to the reality that many healthcare practitioners and staff will have their own personal or familial experience with behavioral health conditions and...
trauma. Education and ongoing support for dealing with the interaction of one’s own history or current status regarding these issues and caring for people with similar difficulties are essential to provision of care. In addition, organizations must address secondary trauma, providing knowledge on what it is and implementing organizational supports to address it.

**Sustainability**

Key to any implementation plan is consideration of sustainability. If an organization makes the initial investment needed to train staff, revise policies and procedures, review mission statements, and engage in a system change, they need to ensure that this change will stick and continue beyond the initial phase of implementation. While full-scale consideration of sustainability was beyond the scope of this panel, they did suggest the following points for consideration:

- **Tie changes to standards** such as the National Committee on Quality Assurance Patient-Centered Medical Home Standards and Guidelines (2014). This can help with initial buy-in as well as sustainability.

- **Institutionalize change.** For example, revising templates within the electronic health record to capture the goals, needs, and preferences of people using services in their own words (Epstein et al., 2010) and documenting the social determinants of health (IOM, 2014) are two concrete ways that organizations can institutionalize universal design principles.

- **Create resource centers.** Resource centers can provide access to materials, toolkits, available services, and other organizations that may be implementing universal design. Additionally, they could house advocacy tools for the peer workforce and people using services to help in navigating systems and hierarchies. The resource center could also include training materials for medical audiences, such as case examples, awareness of trauma and its impact, and principles of recovery.

- **Consider accessibility from the outset.** This means ensuring all education materials are in simple, accessible language and flexible enough to accommodate different communities. Additionally, planners should consult historically underserved communities and incorporate their input. This would include, but is not limited to, individuals from the following communities: LGBTQ, unaccompanied youth, homeless, disabled, deaf or hard of hearing, poor, ethnic and linguistic minorities.

Sustainability plans will be different for each organization. These suggestions may start conversations about sustainability as organization move forward in implementation.

**Next Steps**

A consistent message evolved throughout the two-day panel: To implement universal design in medical homes and hospital settings, a blueprint or roadmap is necessary. This blueprint can provide organizations with a guide for how to move forward in transforming their existing system to one that is recovery-oriented, trauma-informed, and person-centered. The blueprint should draw on existing structures and successes. For example, most licensed practitioners, such as nurses, social workers, psychologists, and physicians, are required to complete yearly continuing education. Ensuring that trainings on universal design can provide the continuing education credits needed for those professionals can ease the time burden while providing needed training. Learning from other organizations that have successfully gone through significant systems change is another valuable avenue to explore.

As universal design is a new framework, building metrics and evaluation into the implementation and sustainability plans is an essential step. While tools exist to measure the separate frameworks involved in universal design, measure development may be part of some organizational plans that capture the impact of universal design as a whole.

Universal design represents a framework that puts the needs of the most vulnerable populations front and center. By providing services for those at the margins of health care and often, society, we can improve services for all.
REFERENCES


Fiscella, K., & Epstein, R. M. (2008). So much to do, so little time: Care for the socially disadvantaged and the 15-minute visit. *Archives of Internal Medicine, 168*(17), 1843-1852.


APPENDIX 1. EXPERT PANEL ROSTER

Participants

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APPENDIX 2. EXPERT PANEL MEETING AGENDA

June 1, 2015

**DAY ONE**

11:00 – 12:50  **PLENARY SESSION ONE**

- 11:00 – 11:20  WELCOME, OPENING REMARKS, AND EXPECTATIONS
- 11:20 – 11:40  INTRODUCTIONS
- 11:40 – 12:00  DISCUSSION: THE NEED FOR TRANSFORMATION
- 12:00 – 12:20  REVIEW AND DISCUSS ISSUES RAISED IN BACKGROUND PAPER
- 12:20 – 12:50  PEER INVOLVEMENT: PERSON-CENTERED AND TRAUMA-INFORMED PRACTICES

12:50 – 1:30  **BREAK**

1:30 – 2:45  **BREAKOUT SESSION ONE**

*Panelists will join designated Breakout Groups*

*Universal Approach: Operationalizing the Framework*

**QUESTIONS FOR BREAKOUT SESSION ONE**

- How do we move from a theoretical framework (presented in this paper) to a practical framework that can be readily implemented in hospitals and medical home settings?
- Given that many of the unique features of both recovery-oriented and trauma-informed care are attitudinal and knowledge-based, how do we operationalize them?
- What practices and guidelines need to be in place to implement this approach?

2:45 – 3:15  **BREAK**

3:15 – 4:45  **PLENARY SESSION TWO**

*Panelists will join designated Breakout Groups*

3:15 - 4:30  REPORT BACK FROM THE GROUPS

4:30 - 4:45  WRAP UP, NEXT STEPS, PLAN FOR TOMORROW
June 2, 2015

**DAY TWO**

11:00 – 11:15  WELCOME

11:15 – 12:15  BREAKOUT SESSION TWO

*Panelists will join designated Breakout Groups*

*Opportunities and Barriers to a Universal Approach*

**QUESTIONS FOR BREAKOUT SESSION TWO**

- What are the opportunities and barriers for implementing such an approach in hospitals and medical home settings?
- What organizational buy-in is necessary?
- What are the regulatory and finance implications?
- What possibilities does ACA provide to implement a universal approach?

12:15 – 1:00  BREAK

1:00 – 2:45  PLENARY SESSION THREE

*All Panelists will join the main meeting room*

1:00 – 1:30  REPORT BACK FROM THE GROUPS

1:30 – 2:15  EXAMPLES OF IMPLEMENTATION IN HOSPITAL AND MEDICAL HOME SETTINGS

2:15 – 2:45  DISCUSSION

2:45 – 3:15  BREAK

3:15 – 4:15  BREAKOUT SESSION THREE

*Panelists will join designated Breakout Groups*

*Discussion on Training, Technical Assistance, and Tools for Implementation of Universal Design*

**QUESTIONS FOR BREAKOUT SESSION THREE**

- What are the training and technical assistance needs?
- What tools and products would be helpful?
- What training/products are needed by medical and behavioral health staff to understand and support peers in medical and integrated settings?

4:15 – 5:00  PLENARY SESSION FOUR

*All Panelists will join the main meeting room*

4:15 – 4:45  REPORT BACK FROM THE GROUPS

4:45 – 5:00  NEXT STEPS, ADJOURN
APPENDIX 3. RESOURCES PROVIDED BY THE EXPERT PANELISTS

- Patients in Context — EHR Capture of Social and Behavioral Determinants of Health
- The Art of Medicine
- Person-centered Care-Ready for Prime Time
- Building a Neighborhood for the Medical Home
- The Pennsylvania Project: Pharmacist Intervention Improved Medication Adherence And Reduced Health Care Costs
- The Partners for Change Outcome Management System
- Six Characteristics of Successful Physician-Hospital Relationships
- A Doctor Discovers an Important Question Patients Should be Asked
- Trauma Informed Care in Medicine
- Treating Patients with Traumatic Life Experiences
- Advancing Behavioral Health Integration with NCQA

Case Studies Websites
Block Center for Integrative Cancer Care
http://www.blockmd.com/

Southcentral Foundation
https://www.southcentralfoundation.com/
Panel Objectives

◆ Define elements of a recovery-oriented approach to care in hospitals and medical home settings.
◆ Identify practices for recovery-oriented care in healthcare settings that are trauma-informed, person-centered and peer-inclusive.
◆ Identify opportunities and barriers to implementing recovery-oriented approaches in these healthcare settings.
◆ Discuss ideas for developing products/resources/toolkit that can be used to help implement recovery-oriented approaches in hospitals and medical homes.

Prior to Meeting

>> Read background paper for the Expert Panel on Promoting a Universal Approach to Recovery-Oriented Care in Hospitals and Medical Home Settings

>> Watch CEO of Iora Health, Dr. Fernandopulle’s video clip: https://www.youtube.com/watch?v=tS0Sk7iKHZQ

Facilitators

Ellen Bassuk, MD, Founder/Senior Technical Advisor Center for Social Innovation

Rachel Latta, PhD, Director of Trauma Initiatives Center for Social Innovation

Jeff Olivet, MA, President/CEO Center for Social Innovation

Robert Sember, MA, Public Health Specialist Center for Social Innovation
PANELIST BIOS

Anika Alvanzo

Anika Alvanzo, MD, MS is a graduate of the George Washington University School of Medicine and Health Sciences and holds a master's degree in biostatistics from Virginia Commonwealth University. She is board certified in both Internal Medicine and Addiction Medicine. Anika is an Assistant Professor in the Division of General Internal Medicine at Johns Hopkins University School of Medicine where she is also the Director of the Substance Use Disorders Consultation Service. In this role she directs a multidisciplinary consultation service that conducts brief behavioral interventions and counseling with patients, facilitates linkage to hospital and community-based alcohol and drug treatment programs, provides guidance on the clinical management of substance withdrawal syndromes, and educates patients, families, healthcare professionals and the community to prevent, identify, and treat persons living with addiction. Anika is also the Director of the Substance Use Disorders Rotation for the Johns Hopkins Medicine-Pediatrics Urban Health and Urban Health Primary Care Residency programs. Her research interests include gender and race/ethnicity differences in the risk for substance use disorders, screening, brief intervention and referral to treatment in diverse settings and the association between psychological trauma, traumatic stress, and substance use. In particular, she is interested in the mechanisms by which history of physical and/or sexual violence confer increased risk for substance use disorders and in the development of technology-delivered interventions for co-occurring traumatic stress and substance misuse in women.

Irvin “Pete” Brock

Dr. Brock’s background in medicine spans more than 40 years and covers medical as well as behavioral domains. After medical school he engaged in academic, operational, and primary care environments as well as in executive leadership positions of large multidisciplinary medical organizations in the U.S. Air Force. He served as the hospital commander for a 25 bed expeditionary medical-surgical hospital during Operation Iraqi Freedom; as deputy chief of psychiatry and chief of outpatient psychiatry for VISN 16 of the VA healthcare system; in private practice as medical director for two free standing psychiatric hospitals as well as running an outpatient general and geriatric psychiatric practice. He has cared for Public Sector as well as insured members in both inpatient and outpatient levels of care.

In 2008 he took a position as associate medical director in a newly created Public Sector division of Optum Behavioral Solutions (formally known as UBH). In this role he engaged nationally based care coordination teams to identify and mitigate service systems gaps as well as inefficiencies in care delivery. He recognized in order to keep members in their communities and to achieve the New Freedom Commission’s aspirations there had to be adequate and appropriate alternatives to institutional based care and traditional services systems. He recognized the importance of a consumer centric view of service delivery, grounded in core principles of recovery and resiliency.

In his most recent position as SVP of Affordability, he leads a team of 21 senior BH clinicians who represent a $1.8B risk portfolio of national Employer, Healthplan, Medicare Advantage and state Medicaid behavioral health plans. Their mission is to take a recovery and resiliency based approach to achieving the triple aims. His team are engaging many issues including the expansion of Medicaid enrollment and benefits associated with the ACA in multiple states, enhanced care coordination for dual eligible (MMA/MME) members, improving access through tele-psychiatry, expanding the use of peer based services as well as other community based services to keep members in their community. Pete’s approach is centered on a continuous and iterative cycle of data analysis, formal solution generation and outcome measurement.

Susan Burton

Drawing on her personal experiences, Susan founded A New Way of Life Re-Entry Project (ANWOL) in 1998, dedicating her life to helping others break the cycle of incarceration. Susan has earned numerous awards and honors, and is widely recognized as a leader in the criminal justice reform movement. A past Soros Justice Fellow, Women’s Policy Institute Fellow and Community Fellow under the California Wellness Foundation’s Violence Prevention Initiative, Susan has served on the state’s Little Hoover Commission and the Gender Responsive Strategies Task Force.

Susan is co-founder of All of Us or None (AOUON) and the Formerly Incarcerated and Convicted People’s Movement (FICPM), both national grassroots civil rights movements composed of formerly incarcerated individuals, their families and community allies. In collaboration with UCLA’s Critical Race Studies Program, Susan launched the Employment Rights Re-Entry Legal Clinic, which has grown to be the largest of its kind in Southern California. For her work, Susan was named a CNN Top
Ten Hero in 2010 and the prestigious Citizen Activist Award from the Harvard Kennedy School of Government. Los Angeles County Supervisor Mark Ridley-Thomas appointed Susan to the Los Angeles County Sybil Bran Commission for Institutional Inspections. In this role she is authorized to inspect Los Angeles County correctional facilities and advocate for the health and well being of people housed in the facilities.

Susan was named 2014 recipient of the James Irvine Leadership Award for “improving the lives of thousands of Californians through strategies that are responsive, collaborative and forward-looking.” In 2015, the Los Angeles Times named Susan as one of eighteen New Civil Rights Leaders in the nation.

Tod Citron

Tod Citron is the CEO of the Cobb & Douglas Community Services Boards; a $35 million, 500 employee, hybrid public-private behavioral healthcare provider organization located in suburban Atlanta that serves approximately 14,000 primarily low income/most-in-need clients annually. He has served in this role for the past 15 years and has worked in the health/human services field for over 25 years. Previously, Mr. Citron was the Administrative Director of the behavioral healthcare programs at HCA’s West Paces Medical Center and Parkway Medical Center, both located in the Atlanta area. He received a bachelor’s degree, double majoring in psychology and communications from the State University of New York at Oswego; and holds a Master of Social Work degree from Atlanta University as well as a Master of Science degree in Healthcare Policy & Administration from the Stetson School of Business and Economics at Mercer University. He is a past President of the Cobb Community Collaborative, Inc. and of Peachstate Information Network, Inc. and is a past Chairman of the CEO Interest Group for the Georgia Association of Community Service Boards, Inc. Presently, he serves as the Chairman of Select Systems/LLC, and as co-chairman of the Cobb HUD Continuum-of-Care; and serves on the board of directors of the Georgia Supportive Housing Association, Inc. and the North Georgia Partnership for Behavioral Healthcare, Inc.; Mr. Citron has served as an adjunct professor in the Health and Human Services Department at Kennesaw State University. In 2010, he was the recipient of the William E. (Bill) Hanson Collaboration Award.

Shane Coleman

Shane was born and raised in Alaska having grown up in North Pole, Alaska. He completed his medical training at the University of Washington as a member of the Alaska WWAMI class of 2007 and went on to complete his adult psychiatric residential training at Massachusetts General Hospital/McLean/Harvard in Boston, MA in 2011. Following residency, Dr. Coleman received a Ruth L. Kirschstein National Research Service Award through NIH and spent two years in fellowship studying the interaction between chronic medical illness and mental health under the mentorship of Dr. Wayne Katon and Jurgen Unutzer. During this time, he gained experience and performed research with integrated systems of care and obtained a MPH degree from the University of Washington. Areas of focus for Shane throughout his career having included research in the areas of depression in HIV, depression in Diabetes, systems of integrating mental health services into primary care, and working with underserved populations. Dr. Coleman is currently serving as Division Medical Director of Behavioral Services at Southcentral Foundation and helps provide direction for the integration of mental health services into primary care, behavioral services, research, as well as QA/QI efforts within the division.

Larry Davidson

Larry Davidson is currently a Professor of Psychiatry at the Yale School of Medicine, where he founded and directed the Program for Recovery and Community Health. Larry has accumulated extensive experience over the previous 25 years partnering with patients, family members, and practitioners in conducting studies focusing primarily on processes of recovery in serious mental illnesses and the development of innovative community-based interventions to promote access to care and the recovery and community inclusion of adults with serious mental illnesses and addictions. These interventions include peer support, social engagement, relapse prevention, person-centered care planning, and community inclusion programs which have been funded by a range of federal (NIMH, NIDA), private (e.g., NARSAD), and state and local resources. Approximately 175 of his 300+ publications have been generated by these projects. In addition to research and program development, Larry has served as Mental Health Policy Director for the State of Connecticut and Director of the national Recovery to Practice Initiative of the U.S. Substance Abuse and Mental Health Services Administration; positions in which he has been able to translate what he learned from research into policy and practice.
Julian D. Ford is the Director and Principal Investigator of the SAMHSA-funded Center for Trauma Recovery and Juvenile Justice and has served as a consultant for SAMHSA Trauma-Informed Care projects for more than 15 years. His research over the past two decades focuses on developing and validating psychometric assessments (such as the Traumatic Events Screening Instrument, the PTSD Checklist for Children/Parent Report, and the Developmental Trauma Disorder Structured Interview) and psychosocial interventions (such as TARGET: Trauma Affect Regulation-Guide for Education and Therapy) for youth, adults, and families who have experienced traumatic adversity, as well as clinical epidemiological studies of health care utilization by adults with behavioral health problems and histories of trauma.

Pamela Greenberg

Pamela Greenberg is the President and CEO of the Association for Behavioral Health and Wellness; she joined the organization in 1998 as the Executive Director for the American Managed Behavioral Healthcare Association (AMBHA). ABHW is the national voice for specialty behavioral health and wellness companies. ABHW member companies provide services to more than 125 million people in both the public and private sectors to treat mental health, substance use and other behaviors that impact health and wellness.

Pamela serves on the Editorial Board of the Bloomberg BNA Health Insurance Report and BEHAVIORAL HEALTHCARE magazine. She is a member of the National Committee for Quality Assurance MBHO Advisory Committee and a liaison to the Standards Committee. In 2015 Ms. Greenberg joined the Advisory Board of Landmark Health, a company that provides home-based medical care to individuals with multiple chronic conditions.

She also was the Chair of the Coalition for Fairness in Mental Illness Coverage, one of the leading Coalitions that helped develop, advocate for, and get the Wellstone-Domenici Mental Health Parity and Addiction Equity Act of 2008 signed into law. She also served as President of ACMHA: The College for Behavioral Health Leadership.

Prior to joining ABHW Pamela was the Deputy Director of Federal Affairs for America’s Health Insurance Plans (AHIP). Before joining AHIP Ms. Greenberg was a Legislative Assistant at Capitol Associates, a healthcare consulting firm in Washington, D.C.

Pamela has a B.A. from Mount Holyoke College and a Masters in Public Policy from Georgetown University. She is also a Board member of the Lupus Foundation of DC/MD/VA.

Charlotte Gyllenhaal

Charlotte Gyllenhaal is the Research Manager at the Block Center for Integrative Cancer Treatment. In this capacity she has been involved in all aspects of the research endeavor, including grant writing, preparation of human subjects protocol forms and study coordination of clinical trials. The Block Center has participated in four industry-sponsored clinical trials in the past three years, and she has worked as study coordinator in all of them. She is also very familiar with the Life Over Cancer integrative medicine intervention at the Block Center, having participated in the very substantial literature review and clinical observations that underlie this system. Charlotte acts as a support person for the Block Center clinical staff, researching a variety of questions raised in patient visits, both medical and integrative. She is involved in program development activities, most recently designing and training staff in a new assessment program for patients. Charlotte also acts as the Managing Editor for the peer-reviewed journal Integrative Cancer Therapies, managing all aspects of article submission, assignment to associate editors, and review, while coordinating decision-making with the Editor-in-Chief. She retired from the University of Illinois at Chicago in 2012, but remains as an adjunct, teaching classes in herbal medicine for pharmacy students as well as supervising pharmacy students doing rotations at the Block Center.

Melissa Lemmer

Melissa Lemmer is a Nebraska native. Her work experience includes: Patient Advocate at Nebraska’s state psychiatric hospital, a certified peer specialist at a local hospital, and most recently a benefits specialist/program coordinator for a consumer run organization. Melissa is an advanced level Wellness Recovery Action Plan (WRAP) facilitator and she played a significant role in bring WRAP to Nebraska and has been facilitating groups since 2004. Melissa authored Nebraska’s Consumer Voice: Leading a Change in Mental Health Services a white paper at the conclusion of a three year SAMHSA grant on promoting system transformation from a medical to a recovery model.
Darby Penney

Darby Penney, M.L.S., is a long-time activist in the human rights movement for people with psychiatric histories. She is a Senior Research Associate at Advocates for Human Potential, Inc., in Albany, NY, where she has worked on SAMHSA-funded evaluation, writing, and training and technical assistance projects on trauma, peer support, shared decision-making, homelessness, and related topics. She co-authored Engaging Women in Trauma-Informed Peer Support: A Guidebook. She and her colleague Cathy Cave developed a 2-day curriculum based on the guide, and have delivered the training to hundreds of people across the U.S. Darby was formerly Director of Recipient Affairs at the New York State Office of Mental Health, where, for 10 years, she brought the perspectives of people with psychiatric histories into the policymaking process. She is co-author with Peter Stastny of The Lives They Left Behind: Suitcases from a State Hospital Attic, based on a multi-method qualitative study of the lives of state hospital inmates from the 19th and 20th centuries.

Joe Powell

Joe Powell is the Executive Director of the Association of Persons Affected by Addiction (APAA), an organization for people seeking or in recovery, family members and allies. In 1998, APAA was one of the first SAMHSA/CSAT–funded Peer–to–Peer Recovery Community Support Projects. APAA recently made history by signing the first addiction recovery contract with the managed-care company, Value Options, for Peer–to–Peer recovery support services. Joe participated as a member of the Texas team in the 2011 BRSS TACS Policy Academy. He has also participated in several SAMHSA initiatives, including Co–occurring Substance Use and Mental Illness Report to Congress, SAMHSA/CMHS/Dallas County Transformation of the Mental Health System and the Texas Recovery Initiative. Joe is in long–term recovery with 21 years free of alcohol and other drugs. He is a licensed Chemical Dependency Counselor who has treated and served individuals with addictions and co–occurring mental illness and substance use problems for 18 years in Dallas, TX. Joe started the first African American National Alliance for Mental Illness (NAMI) in Dallas in 1998. He recently sat on the following Board of Directors; Texas Recovers, National Faces and Voices of Recovery, National and Regional Addiction Technology Transfer Center Advisory, The (NLC) National Leadership Council for Behavioral Health for African Americans, Mental Health America (MHA) Texas and the National Alliance for Multicultural Behavioral Health Association, Addiction Technology Transfer Center Regional and National Advisory Board, SAMHSA/CSAT Recovery Month Planning Partners and a National Council on Alcohol and Drug Dependence (NCADD) affiliate. In addition, he serves on the Social Work/Substance Abuse advisory board for Eastfield College in Dallas, TX.

Janice Pringle

Dr. Jan Pringle is an epidemiologist by training with extensive experience in health services research. She is the founder and Director of the Program Evaluation Research Unit (PERU) within the University of Pittsburgh School of Pharmacy. Her particular area of expertise includes addiction services research, especially research involving the application of screening, brief intervention and referral to treatment (SBIRT) within various healthcare settings. She has conducted numerous health services research studies and program evaluation efforts involving innovative addiction treatment, intervention and prevention models. She is the Co-Chair of the Pennsylvania Department of Drug and Alcohol Program’s Clinical Standards Committee, and is a consultant to the Substance Abuse Mental Health Services Administration (SAMHSA) in their review of state behavioral health homes.

Jan was selected as an Innovation Advisor within the Center of Medicare and Medicaid Innovations (CMMI). She has also conducted health services research involving community pharmacy services. She led the evaluation of a Pharmacy Quality Alliance (PQA) funded initiative within Pennsylvania and one funded by Merck, conducted in Tennessee, that involved the application of SBIRT techniques by community pharmacists for the purpose of improving medication adherence. Jan has also conducted a number of other medication adherence studies involving the application of other strategies within different healthcare settings. Throughout her career, Jan has secured over $120 million in grants from a variety of sources, and she has developed healthcare policy research and briefs that have been used to inform policy development at both the state and federal level.

Sheela Raja

Sheela Raja, PhD is a Licensed Clinical Psychologist. She is an Assistant Professor of Dentistry and Medicine at the University of Illinois at Chicago where she teaches Health Communication and Behavioral Medicine. She is the author of author of Overcoming Trauma and PTSD and the upcoming Sexual Trauma Workbook for Teen Girls (New Harbinger Press). She received her PhD from the University of Illinois at Chicago and completed internship and post-doctoral training at the National Center for Post-Traumatic Stress Disorder in Boston, MA. She has published numerous peer-reviewed articles exploring the
relationship between physical and psychological health and traumatic events. Her current research interests include training medical providers to work effectively and sensitively with survivors of trauma. She has given invited talks to federal, state and community agencies and is a regular contributor to various print and national television media outlets, including the Huffington Post, CNN and CBS-2 Chicago morning news.

Iyah Rohm

Iyah Romm leads the Care Delivery Innovation and Investment Team at the Health Policy Commission in efforts to accelerate health system transformation, including a particular focus on developing policy and leveraging investments to increase appropriate community-based hospital use, improve efficiency, and promote effective allocation of health care resources. Prior to joining the HPC, Iyah served as Special Advisor to the Commissioner of the Department of Public Health (DPH). Over several years, including two stints at DPH, Iyah's responsibilities ranged from strategic and organizational planning, policy development, and oversight of the Department's policy response to the recent nationwide fungal meningitis outbreak. He oversaw policy and strategy for the DPH health care regulatory arm, including Determination of Need, emergency medical services, and health care facility licensure, and quality improvement. Prior to his government career, Iyah led quality and care delivery initiatives in settings ranging from academic medical centers to post-earthquake Haiti to community-based organizations in Boston. He is a graduate of Brandeis University and additionally studied medicine at Boston University.

Alexander Ross

Dr. Alex Ross is senior advisor on behavioral health in the Division of Nursing and Public Health, Bureau of Health Workforce at the Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services. In addition to focusing on behavioral health workforce programs, Alex supports HRSA Bureaus and Offices fostering the integration of behavioral health and primary care. Alex's work has included an emphasis on financing issues regarding behavioral health/primary care services and assuring that an appropriately trained health care workforce is available to meet the Nation's needs. In addition to his current work, Alex has held positions at HRSA in the Office of Planning and Evaluation, the Bureau of HIV/AIDS, and the Office of Public Health Practice. Alex has a Doctor of Science Degree in Health Policy from The Johns Hopkins University School of Hygiene and Public Health.

Greg Wilmot

Gregory Wilmot is the Director of Business and Network Development at Boston Medical Center (BMC). At BMC, Gregory partners with clinical and administrative leaders in the hospital and across key partners to create new ideas for growth, working closely with clinical departments to implement new initiatives that support the hospital's growth, patient satisfaction, and quality goals. He is also responsible for improving hospital revenue generation and strengthening the hospital's market presence.

Prior to joining Boston Medical Center, He worked for the Executive Office of Health and Human Services (EOHHS), where he led strategy and business planning and performance management. EOHHS is the largest Commonwealth and its work touches the lives of all Massachusetts residents. As the Director of Strategic Planning and the Office of Performance Management, Gregory championed and facilitated positive, lasting, and meaningful improvement of the state's health and human services delivery system, including the development of EOHHS' first multi-year strategic plan. Among other accomplishments, He led the state-wide effort to develop a comprehensive plan for strengthening children, youth, and family services for residents of Massachusetts. He also co-led the implementation and management of Governor Patrick's youth violence prevention initiative, an $18M statewide violence prevention initiative launched in 2012.

Prior to joining EOHHS, Gregory worked for Blue Cross Blue Shield of Massachusetts (BCBSMA). He held roles in various areas within the organization, including the company's Business Risk Management, Underwriting, Corporate Audit, Customer Financial Management and Billing Operations, Claims Operations, and Financial Services and Analytics departments.

Gregory serves as a member of the Board of Directors for the Dimock Center. He also served as a board member for Shore Day Care / Stars, a provider of early education and youth development programs for communities south of Boston. He also served as President of the Board of Directors for the Dorchester Branch YMCA. Gregory also served as a member of the Boston College Alumni Association Board of Directors’ Student Involvement Committee. For his civic leadership in the South Shore and Greater Boston communities, Gregory received the Stars’ 40 Under 40 award in 2010. He earned a BA in Psychology from Boston College, and holds an MBA from Northeastern University with a specialization in Investments.
Steven Wright

Steven Wright, MD, was in family medicine for 32 years. He was active in addiction medicine (board certified) for 27 years and medical pain management for 12 years; his aim is to build sober and pain-managed persons and communities through evidence-based, personalized, and respectful medical approaches. No longer in private practice he focuses on care of pain and addicted persons provided by others: consulting, speaking, advocacy, policy development, education, medical provider assessment, medical provider clinical supervision, and medical-legal work.

Steve’s clinical interests include the neurophysiology and treatment of pain and addiction – in particular: etiology, pharmacogenetics, opioids, psychiatric medications, cannabis, adverse consequences, best practices, and systems of care. He sees balancing optimal medication with safety as much an art as it is science, a “symphony” essential for patients and the communities in which we all live.

Steve actively participates in the Colorado Pain Society (vice president / physician liaison), the Colorado Society of Addiction Medicine (secretary-treasurer / delegate to the Colorado Medical Society), the Prescription Drug Abuse Committee of the Colorado Medical Society, and the Colorado Consortium for Prescription Drug Abuse. He is involved in a variety of related projects and speaks across the country on opioids, opioid-induced constipation, cannabis, pharmacogenetics, and risk managing controlled medication use.
Tips for Working the Virtual Meeting Room

Be Prepared
Please be sure to have login information and all necessary documents together at least one hour before the scheduled meeting time. Review the meeting agenda, paying careful attention to the indicated time zone.

Be On Time
Please login to the meeting at least 15 minutes early and check your setup to ensure that your devices are properly configured. If something is preventing you from attending on time, please let the host know, so they can be sure to help you if necessary. If you know ahead of time that you are going to be late, please inform the host so the meeting can still begin on time.

Stay Focused
While it is tempting to multi-task, doing so may inhibit you from fully participating in the conversation. Please treat this meeting as you would a face-to-face meeting and be as present and participatory as possible.

Speak Up
Please speak loudly and clearly. If you are participating using a webcam, try to look directly at your camera. Please be sure to mute your phone when you are not speaking to avoid introducing any unnecessary sound and background noise while others are speaking.

You can mute and un-mute your phone by dialing *1 on your phone keypad.

Be Brief
Virtual meetings are not conducive to longer conversations. Please try to keep your responses and questions brief and concise, allowing time for everyone to participate. If you have a longer point you would like to make, use the chat box to articulate that thought. Out of respect for the limited time together, please try to keep your remarks and questions on topic.

Use the Chat Box
If someone is presenting or speaking, please let them finish before asking questions or contributing to the conversation. The chat box is a great way to ask questions or contribute to the conversation as well, even while someone else is speaking.

Use the Webcam
If you are using a webcam to participate, please find a quiet space with overhead lighting and minimal foot traffic. Remember that other participants will be able to see any movement behind you.

If You Need to Leave Your Computer
If you need to step out of the meeting, even for a short time, please be sure to let the facilitators know. Pause or stop your webcam if you step away from your desk. For longer absences, please remember to disconnect from the meeting room.
BRSS TACS Virtual Expert Panel: Promoting a Universal Approach to Recovery-Oriented Care in Hospital and Medical Home Settings
June 1 & 2, 2015

Welcome from SAMHSA

Marsha L. Baker
Public Health Advisor, SAMHSA/CSAT
BRSS TACS Project Officer

Peter Gaumond
SAMHSA/CSAT
Introduction to BRSS TACS

Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS)

SAMHSA’s 6 Strategic Initiatives

#1 – Prevention of Substance Abuse and Mental Illness
#2 – Health Care and Health Systems Integration
#3 - Trauma and Justice
#4 – Recovery Support
#5 – Health Information Technology
#6 – Workforce Development

Four Dimensions of Recovery

HOME ↓ Permanent Housing

COMMUNITY ↑ Peer/Family/Recovery Network Supports

PURPOSE ↓ Employment/Education

HEALTH ↑ Recovery Health Wellness

Individuals and Families
BRSS TACS – Major Goals

- Engage and promote leadership of people in recovery at all levels of State and local systems and services
- Disseminate state-of-the-art information on recovery supports and services
- Through cross-sector collaboration, implement Recovery Support Action Plans for States, Territories, Tribes, and communities
- Promote peer-driven, recovery-oriented systems of care

Major Activities – Funding Opportunities

- **2015 Peer Health Reform Efforts**: $40,000 each for up to 8 organizations to undertake outreach and dissemination efforts to educate people in recovery about health care reform
- **Peer-Run Organization/Recovery Community Organization Projects to Promote Best and Emerging Practices**: $40,000 each for up to 8 organizations to promote the adoption of peer-delivered recovery-oriented services

Virtual Policy Academy

**2015 Policy Academy**: Five states will develop outcome-focused Recovery Action Plans. Each team that successfully creates an approved Action Plan will be eligible for a $75,000 fixed-price subcontract to support Action Plan implementation

- Alabama Department of Mental Health
- Idaho Department of Health and Welfare
- New Hampshire Bureau of Drug and Alcohol Services
- The Oklahoma Department of Mental Health and Substance Abuse Services
- Wyoming Department of Health, Behavioral Health Division
National Summit

• The 2015 National Summit will comprise three Regional Summits in Atlanta, Vancouver and Baltimore respectively. The focus is Peer Providers in the Behavioral Health Workforce

• The 2014 National Summit on Health Technology: A Vehicle for Advancing Person-Centered, Recovery Oriented Care took place in Kansas City, Reno and Atlanta

Technical Assistance

Examples include:
1. Developing and Implementing a Recovery Coaching Curriculum
2. Infusing recovery-oriented values into policies & regulations
3. Core competencies for recovery-oriented behavioral health workers
4. Leadership by people in recovery

BRSS TACS Expert Panel

Moderator

Jeff Olivet
President/CEO
Center for Social Innovation
June 1, 2015 | Day One

11:00 – 12:50  PLENARY SESSION ONE
• Welcome, Opening Remarks, And Expectations
• Introductions
• Discussion: The Need For Transformation
• Review And Discuss Issues Raised In Background Paper
• Peer Involvement: Person-centered And Trauma-informed Practices

Panel Objectives
• Define elements of a recovery-oriented approach to care in hospitals and medical home settings.
• Identify practices for recovery-oriented care in healthcare settings that are trauma-informed, person-centered and peer-inclusive.
• Identify opportunities and barriers to implementing recovery-oriented approaches in these healthcare settings
• Discuss ideas for developing products/resources/toolkit that can be used to help implement recovery-oriented approaches in hospitals and medical homes.

Overarching Goal
Create an Operational Blueprint
June 1, 2015 | Day One

Welcome

Introductions: Breakout Session Facilitators

- Ellen Bassuk, MD, Founder/Senior Technical Advisor
  Center for Social Innovation
- Rachel Latta, PhD, Director of Trauma Initiatives
  Center for Social Innovation
- Jeff Olivet, MA, President/CEO
  Center for Social Innovation
- Robert Sember, MA, Public Health Specialist
  Center for Social Innovation

Introductions: The Panelists
DISCUSSION: THE NEED FOR TRANSFORMATION

PEER INVOLVEMENT: PERSON-CENTERED AND TRAUMA-INFORMED PRACTICES

12:50 – 1:30 BREAK
June 1, 2015 | Day One

1:30 – 2:45  BREAKOUT SESSION ONE
Universal Approach: Operationalizing the Framework
Panelists will join designated Breakout Groups
QUESTIONS FOR BREAKOUT SESSION ONE
• How do we move from a theoretical framework (presented in this paper) to a practical framework that can be readily implemented in hospitals and medical home settings?
• Given that many of the unique features of both recovery-oriented and trauma-informed care are attitudinal and knowledge-based, how do we operationalize them?
• What practices and guidelines need to be in place to implement this approach?

June 1, 2015 | Day One

2:45 – 3:15  BREAK

June 1, 2015 | Day One

3:15 – 4:45  PLENARY SESSION TWO
All Panelists will join the main meeting room
• Report Back From The Groups
• Wrap Up, Next Steps, Plan For Tomorrow
June 1, 2015 | Day One

REPORT BACK FROM THE GROUPS

June 1, 2015 | Day One

WRAP UP, NEXT STEPS, PLAN FOR TOMORROW

June 2, 2015 | Day Two

11:00 – 11:15 WELCOME
11:15 – 12:15  BREAKOUT SESSION TWO
Opportunities and Barriers to a Universal Approach
Panelists will join designated Breakout Groups
QUESTIONS FOR BREAKOUT SESSION TWO
• What are the opportunities and barriers for implementing such an approach in hospitals and medical home settings?
• What organizational buy-in is necessary?
• What are the regulatory and finance implications?
• What possibilities does ACA provide to implement a universal approach?

12:15 – 1:00  BREAK

1:00 – 2:45  PLENARY SESSION THREE
All Panelists will join the main meeting room
• Report Back From The Groups
• Examples Of Implementation In Hospital And Medical Home Settings
• Discussion
June 2, 2015 | Day Two

2:45 – 3:15 BREAK

3:15 – 4:15 BREAKOUT SESSION THREE
Discussion on Training, Technical Assistance, and Tools for Implementation of Universal Design
Panelists will join designated Breakout Groups
QUESTIONS FOR BREAKOUT SESSION TWO
• What are the training and technical assistance needs?
• What tools and products would be helpful?
• What training/products are needed by medical and behavioral health staff to understand and support peers in medical and integrated settings?

June 2, 2015 | Day Two

4:15 – 5:00 PLENARY SESSION FOUR
All Panelists will join the main meeting room
• Report Back From The Groups
• Next Steps, Adjourn
REPORT BACK FROM THE GROUPS

NEXT STEPS, ADJOURN

THANK YOU
Passage of the Patient Protection and Affordable Care Act in 2010 initiated a series of far-reaching changes to how health care in the U.S. is funded, structured, delivered, and evaluated. The legislation may be seen as an attempt to implement the strategy called for a decade earlier by the IOM in its report, Crossing the Quality Chasm: A New Health System for the 21st Century (2001). The strategy included identifying best practices, changing the payment systems to stimulate improved care, and implementing legal and regulatory reform to make health care systems more conducive to continual improvement. The Affordable Care Act also adheres to the IOM’s recommendation that person-centered care be a central feature of a 21st century healthcare system. The legislation includes numerous references to service-user satisfaction, experience of care, and engagement and shared decision-making. The commitment to person-centered care carries through to the mandated measures of the quality of care, public reporting, and performance payments (Millenson & Macri, 2012). Below, we provide examples of Affordable Care Act initiatives that illustrate both the opportunities and challenges for using health reform processes that advance person-centered care.

The Affordable Care Act's scale and reach bring considerable power to change practices. The reforms have expanded access to affordable health insurance while requiring almost all U.S. residents to purchase coverage or pay a fine. Millions of people who lacked coverage are now enrolled in affordable insurance plans. For many new enrollees the insurance premiums are offset by federal subsidies. Additionally, millions of individuals living at or below 133% of the Federal Poverty Level (FPL) have or are now eligible to enroll in expanded Medicaid programs. The 2012 U.S. Supreme Court ruling on the constitutionality of the Affordable Care Act affirmed that states have a choice to expand Medicaid eligibility. To date, 35 states have either expanded or are considering expanding eligibility (Henry J. Kaiser Family Foundation, 2015). The divide between the states complicates efforts to institute universal standards of care. Nevertheless, as we discuss below, the Centers for Medicare and Medicaid Services (CMS) are supporting many of the innovations enabled by the Affordable Care Act.

Additional changes initiated by the Affordable Care Act include expanded Medicare drug benefits, removal of preexisting condition exclusions, and the requirement that eligible insurance products cover Essential Health Benefits (EHB), which are treatment and services in 10 key areas, including behavioral health. The mandatory inclusion of addiction and mental health services in all health insurance benefit packages was underscored by incorporating the Mental Health Parity and Addictions Equity Act of 2008 into the Affordable Care Act. The Parity Act enshrines into law equity between behavioral health and other medical benefits. The Affordable Care Act also limits cost sharing and premium requirements, and authorizes significant funding to states, local governments, employers, community organizations, and other entities through grants and programs to implement the many provisions in the law (Henry J. Kaiser Family Foundation, 2012a). In 2012, the Federal funding levels for the Affordable Care Act were estimated to be $12.2 billion, with $4 billion going to states and $8.2 billion allocated to the private sector (Henry J. Kaiser Family Foundation, 2012b).

The Affordable Care Act takes advantage of Medicare, Medicaid, and Children’s Health Insurance Program (CHIP) to advance innovation in financing and service delivery. These programs enable the federal government to assert its authority as both a purchaser of healthcare services, and author and enforcer of policy. The Affordable Care Act mandated CMS to test innovative payment and service delivery models in accordance with the requirements of section 1115A of the Social Security Act, which gives the Secretary of Health and Human Services (HHS) authority to approve pilot, experimental, or demonstration projects that promote the objectives of Medicare and Medicaid programs (SAMHSA, 2012). States that receive Section 1115 waivers can implement and evaluate design and policy initiatives that deviate from standard CMS systems and policies. Among the models the Innovation Center set out to test were Federally Qualified Health Center (FQHC) Advanced Primary Care Practice patient-centered medical homes and health homes for high-need individuals (Moses & Ensslin, 2014). If these demonstration projects are deemed successful at reducing costs, achieving projected medical outcomes, and promoting long-term wellness, they could facilitate widespread adoption of elements of person-centered care (Cassidy, 2010).

While medical homes vary widely in structure and approach, it is possible to identify a set of shared principles and elements (Moses & Ensslin, 2014). People using services, often with the active participation of their families, work closely with a
designated physician, nurse practitioner, or physician assistant on their continuing care. The designated medical professional is responsible for coordinating care and making referrals to specialists. Electronic health records facilitate a continuum of care, which includes linking individuals to non-medical social services that support wellness and reduce the risk of medical crises that may require costly emergency care and hospitalization. Health homes are similar to medical homes, but tend to emphasize the integration with public health and the potential for advance practice nurses to coordinate care. To be eligible for medical home services, an individual must be diagnosed with either:

1. Two chronic conditions,
2. One chronic condition and risk for a second, or
3. A serious mental illness.

Continuity in the partnership between practitioners and people seeking services and emphasis on the active participation of people seeking services in all treatment decisions reflects the importance of engaging people seeking services, especially those with chronic illnesses.

States implementing Patient-Centered Medical Homes receive an enhanced 90/10 federal match for the first eight fiscal quarters of the program. States view this model as a way to move away from fee-for-service reimbursement and 15-minute service slots toward more meaningful value-based purchasing (David, Abrams, & Stremikis, 2011). Almost all states with Medical Home programs use a bundled payment approach, usually in the form of a per-member-per-month (PMPM) payment (SAMHSA, 2012). Among the benefits of this approach is the freedom to pay for services that have historically been difficult to reimburse, such as virtual contacts, home visits, and care coordination (Cassidy, 2010).

The three-year Federally Qualified Health Center Advanced Primary Care Practice demonstration to investigate how the patient-centered medical home model can improve quality of care, promote better health, and lower costs concluded on October 31, 2014. Once the data are analyzed the results will be published on the CMS website. The HHS secretary has the authority to expand the use of models like patient-centered medical homes within Medicare or Medicaid.

CMS is exploring the benefit of shifting from fee-for-service and procedure-based payment systems to various other programs. Fee-for-service systems reward the quantity of services offered by practitioners rather than the overall quality of care people seeking services receive. This inclines service systems toward fragmented care. Alternatives include the shared-savings and incentive-pay approach that rewards primary care practices with more money if they are able to improve quality of care and avoid expensive and unnecessary emergency department visits and hospital admissions (Green et al., 2014). In January 2013, CMS announced the health care organizations selected to participate in the Bundled Payments for Care Improvement initiative. The selected organizations assume financial and performance accountability for episodes of care. The aim is to determine if these models will lead to higher quality and more coordinated care at a lower cost to Medicare. Research has shown that bundled payments reward practitioners that work closely together across all specialties and settings. Increased coordination may place the people seeking services at the center of care so that hospitals, post-acute care practitioners, physicians, and other practitioners’ incentives will align with the long-term wellness goals of people seeking services. With the stress lifted from the consumption of services and increased coordination, the voices of people seeking services may feature more prominently in developing and implementing care plans.

In the Hospital Value-Based Purchasing (HVBP) program, the experiences of people seeking services are an increasingly prominent concern (Hooten, 2014; Millenson & Macri, 2012). HVBP links a portion of CMS payments to Inpatient Prospective Payment Systems (IPPS) that in turn are linked to performance on a set of measures of the quality of care and experiences of people seeking services. The HVBP program predates the Affordable Care Act, but health reform has expanded this program by requiring a consensus-based entity to advise HHS on the measures to be used for public reporting, value-based payment, and other programs. HHS selected the National Quality Forum (NQF), which in turn created a special Measure Applications Partnership (MAP) to provide input related to Affordable Care Act requirements (Institute of Medicine, 2012). Close to a third of the committee members represent consumer organizations (Millenson & Macri, 2014). Measures endorsed by the MAP could establish a clear method for differentiating the various aspects of person-centered care as well as setting national standards for assessing quality of care (Green et al., 2014).
Under the Affordable Care Act, HVBP program links a portion of the hospital’s payment from CMS to performance on a set of quality measures, which include: the Clinical Process of Care Domain, which accounts for 45% of a hospital’s total performance score (TPS); the Patient Experience of Care Domain, which accounts for 30% of TPS; and the new Outcome Domain, which accounts for 25% of TPS. The Affordable Care Act also specifically included the Hospital Consumer Assessment of Healthcare Practitioners and Systems (HCAHPS) performance in the calculation of the value-based incentive payment (HCAHPS Fact Sheet, 2013). Since 2008, this 32-item survey measures perceptions of the hospital experience of people using services. The core of the survey contains 21 items that ask “how often” or whether people seeking services experienced a critical aspect of hospital care, rather than whether they were “satisfied” with their care. Hospitals may add supplemental items after the core HCAHPS items. Domains include:

- Communication with nurses and doctors
- Responsiveness of hospital staff
- Pain management
- Communication about medicines
- Discharge information
- Overall rating of hospitals

HCAHPS has allowed valid comparisons to be made across hospitals locally, regionally and nationally. Except for specific critical access hospitals, the HCAHPS survey is mandatory and is published for public view through the CMS Hospital Compare site. In cases where measures have already been proposed, the MAP is empowered to consider revising these measures in subsequent years. Thus, the opportunity exists to use the HCAHPS and other measures to increase the focus on domains relevant to person-centered care.

In addition to exploring new service delivery approaches, adjusting how health care is funded, and refocusing health care research and evaluation initiatives, health reform is making other changes possible. Many of these redress the comparative lack of focus on person-centered outcomes at the systems level in favor of macro or system-level variables such as total or average expenditures for care in various settings among different practitioners and for specified services (Green et al., 2014). The Institute of Medicine (IOM) is among the groups interested in exploring the treatment options that emerge when person-centered approaches are linked to changing funding mechanisms. For example, penalties for hospital readmissions and rewards for successful population-based health management are fostering attempts to address elements of the lives and behaviors of people seeking services that influence the risk of disease and the effectiveness of medical treatment. To get at key social and behavioral determinants of health, an IOM committee has developed a panel of standard measures that, if implemented, will increase clinical awareness of the health status of people seeking services and enable clinical, public health, and community resources to work together. The committee suggests that these data can facilitate shared decision-making, an essential characteristic of person-centered approaches. With more accurate information on the situation of an individual seeking services, such as his or her financial strain, clinicians can better partner with people seeking services to make informed and realistic medication choices (Institute of Medicine, 2014).

The health reform process is providing numerous opportunities to explore links between person-centered outcomes and the varied payment and reimbursement structures that are redefining the health care system. Comparative Effectiveness Research CER and Service-User Centered Outcomes Research PCOR projects examining alternative financing and distribution approaches resulting from the Affordable Care Act and recent Medicaid waivers could shed light on which contractual elements are most likely to result in improved person-centered outcomes (Green et al., 2014). Advocates for system-wide change face the daunting task of coordinating strategies across the many components of the health reform process and ensuring consistency in person-centered care guidelines and practices. The process is further complicated by the legislation’s range and at times conflicting demands for quality of care, efficiency, and cost-effectiveness. Progress toward an integrated universal approach to person-centered care requires aligning these service delivery practices with the AFFORDABLE CARE ACT’s investment in cost containment and improvement in overall health outcomes.
REFERENCES


