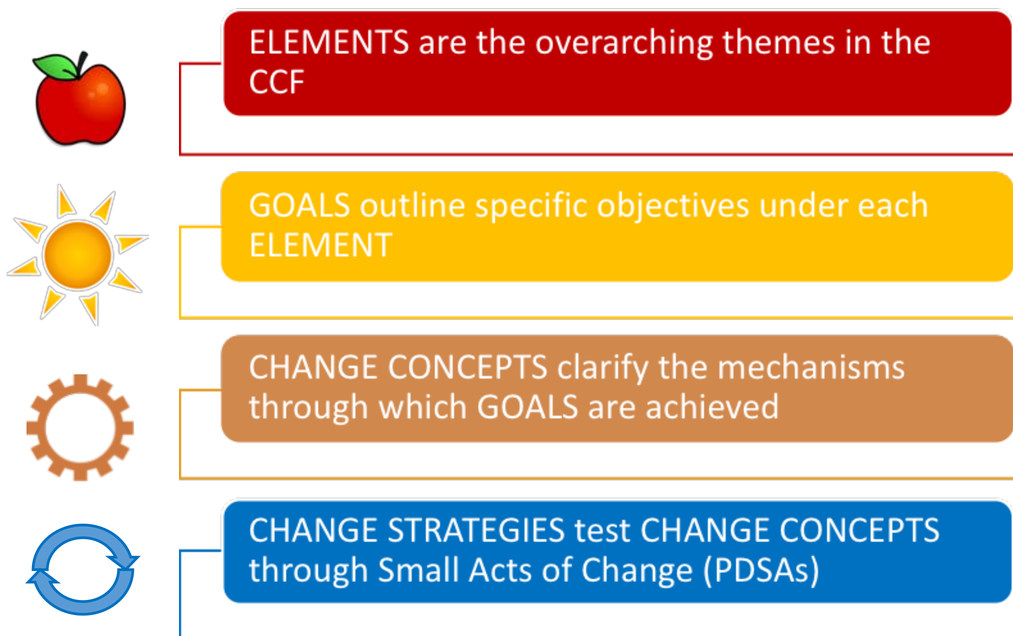
PICC Collaborative Change Framework

This Collaborative Change Framework (CCF) was developed by a multi-disciplinary, inclusive group of experts and refined by the thirty teams that participated in the first round of Pediatric Integrated Care Collaboratives (2013-2016). The goal of this CCF is to outline and describe the key areas in which teams can make change to achieve trauma-informed integrated care for children and families exposed to trauma or chronic stress in your communities.

This CCF is designed to help translate the six core elements into concrete and sustainable practice in everyday work. To support customization and honor the unique strengths and needs of each clinic, organization, agency, and community, teams are not limited to the strategies included here. Instead, possible strategies that you could consider testing or adapting in your own site are included as food for thought. Ideally, most of these strategies could be tested quickly as small tests of change (Plan-Do-Study-Act cycles).

Additionally, examples of metrics that map onto each element are provided at the end of this document. Teams should consider which would be most meaningful to them to ensure that the changes they test are resulting in improvements. Teams may decide that a metric that is not included would be more meaningful or important to them.

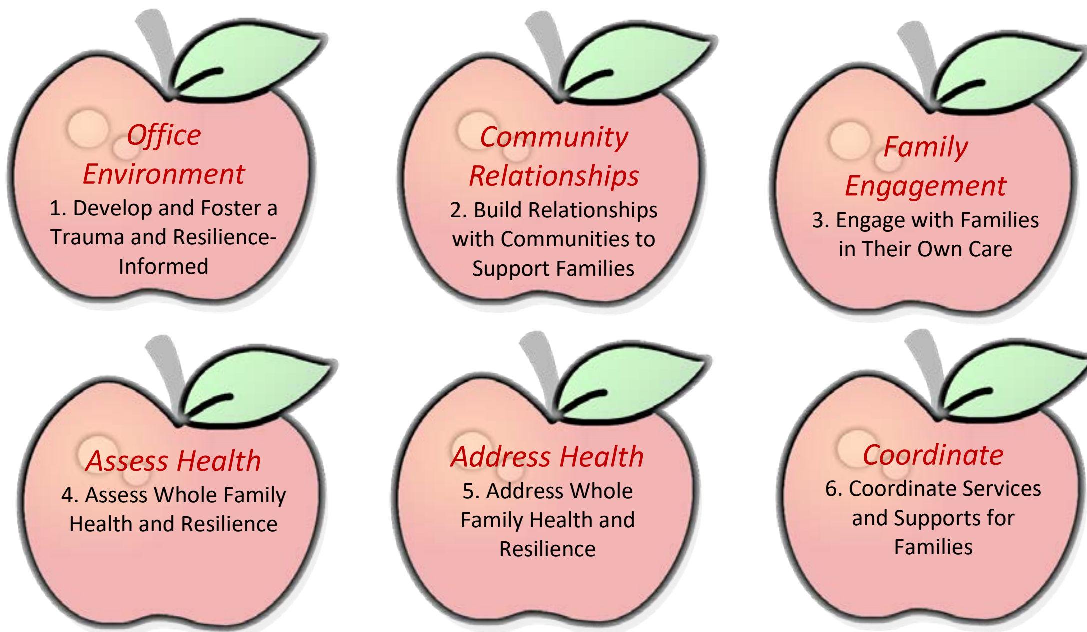
For each of the six elements, you will see the following formatting and terms:



The CCF is divided into six ELEMENTS. Although these elements are inter-related and inter-connected, for the purposes of the Collaborative they have been separated into distinct areas as a way of organizing implementation into manageable pieces. Some elements are specific to trauma/chronic stress, but others could apply to all interactions in the primary care setting. For example, practices that have already committed to attaining "medical home" status may find that they have already built mechanisms to address several of these elements, though perhaps not with specific trauma/stress or early childhood emphasis.

The first three elements are foundational, focused on culture, organizational capacity, structure, and fundamental values. The second three elements are focused on practice – what happens between providers and families.

These six core elements are:



The following pages detail each of these elements, providing goals, change concepts, and change strategies for each.

ELEMENT 1. Office Environment

Develop and Foster a Trauma and Resilience-Informed Environment

Goal 1. Involve Families at the Organizational Level (Service Planning, Implementation, & Evaluation)	A. Develop formal/informal documents to support family involvement at the organizational level	State your commitment to support family involvement
		Set clear expectations (e.g., job description) for family advocate
		Develop clear reimbursement policies for families
		Ensure active leadership support for family involvement
	B. Recruit and support family members who are ready and interested	Think broadly in outreach efforts to recruit families
		Use a buddy system
	C. Provide orientation, training, and support for staff and family members	Orient families to the organization
		Orient families about their role at the agency/system level
		Orient staff about the role of family advocates at the agency/system level
Goal 2. Educate Staff and Partners about Trauma, Resilience, Trauma-Informed Care, and Social Determinants of Health	A. Provide education to all staff about resilience, the impact of trauma, and social determinants of health on children, families, and communities	Provide formal training to staff based on their identified needs
		Share educational materials during staff meetings, in staff newsletters, bulletin boards, and communications
	B. Provide education to staff and partners about how to respond to, support, and address trauma-related problems and social determinants of health as part of primary care	Provide training to staff/ partners about the importance of working with children, their caregivers, and the community to adequately care for the child
		Provide training to staff/partners on the importance of being sensitive and responsive to families' cultural and racial backgrounds
Goal 3. Create and Support a Healthy Office Environment	A. Create an atmosphere and tone in the office that supports psychosocial health and community	Display or place materials, posters, and supplies in the waiting room that demonstrate the values and beliefs of the community
		Rearrange physical space to create a welcoming environment and make people feel psychologically safe
		Offer flexibility in scheduling
	B. Recognize and address self-care needs of all staff	Provide support for staff on a regular and systematic basis
		Build time into staff meetings to acknowledge and respond to staff stress
		Provide training, space, and support for staff on the impact of working with families who have experienced trauma or stress

ELEMENT 2. Community Relationships

Build Relationships with Communities to Support Families

<table>
<tr><th> </th><th>
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<tr><td rowspan="3">Goal 1. Understand the Community’s Strengths and Needs</td><td rowspan="3">A. Identify and “unpack” key community strengths to understand resources, supports, and connections to health</td><td>Conduct community health / wellness assessment that is culturally responsive and reflects how you define your community (e.g., neighborhood, ZIP code, town, etc.)</td></tr>
<tr><td>Develop an understanding of how the community defines trauma/health, how to heal it, and access issues</td></tr>
<tr><td>Provide training on the community’s history (e.g. the relationship between the service site and the community)</td></tr>
<tr><td rowspan="8">Goal 2. Develop Partnerships with Community Partners Focused on Healthy Families</td><td rowspan="3">A. Build relationships with identified community partners</td><td>Host lunches/open houses to connect with community partners</td></tr>
<tr><td>Shadow one another to develop understanding and trust</td></tr>
<tr><td>Identify common values, priorities, and practices</td></tr>
<tr><td rowspan="3">B. Sustain and strengthen partnerships over time</td><td>Use tools to assess partnerships</td></tr>
<tr><td>Identify organizational improvements across organizations</td></tr>
<tr><td>Conduct joint trainings / have joint meetings</td></tr>
<tr><td rowspan="2">C. Include community partners as members of expanded team</td><td>Have meetings at times when community partners can attend</td></tr>
<tr><td>Have clear roles, responsibilities, and expectations for community partners to ensure their time is used well</td></tr>
<tr><td rowspan="11">Goal 3. Develop Partnerships with Medical and Mental Health Specialists Focused on Healthy Families</td><td rowspan="3">A. Build relationships with medical and mental health specialists, recognizing the resources and interventions (e.g., EBTs) they offer</td><td>Host lunches/open houses to connect with mental health specialists</td></tr>
<tr><td>Shadow one another to develop understanding and trust</td></tr>
<tr><td>Identify common values, priorities, and practices</td></tr>
<tr><td rowspan="4">B. Develop communication systems between collaborating medical and mental health partners, including those who typically work with adults</td><td>In health centers that have adult services, cultivate relationships with adult providers.</td></tr>
<tr><td>Create internal referral pathways with adult services.</td></tr>
<tr><td>Include parent issues in child charts and vice versa</td></tr>
<tr><td>Identify staff person to serve as linkage for adult services</td></tr>
<tr><td rowspan="2">C. Sustain and strengthen these partnerships over time</td><td>Identify organizational improvements across organizations</td></tr>
<tr><td>Conduct joint trainings / have joint meetings / provide cross-education</td></tr>
<tr><td rowspan="2">D. Include medical and mental health specialists as members of expanded team</td><td>Have meetings at times and places when specialty partners can attend</td></tr>
<tr><td>Have clear roles, responsibilities, and expectations for specialty partners to ensure their time is used well</td></tr>
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ELEMENT 3. Family Engagement

Engage with Families in Their Own Care

Goal 1. Support Family Partnership in Clinical Discussions	A. Use family-friendly, accessible language when talking with families about their care	Invite family members to reflect on the language used in the clinic and unpack jargon
		Develop family-friendly materials to describe health and wellness
		Add family-friendly language to forms and other documents families need to complete
	B. Communicate with families in respectful, open, supportive ways	Clearly introduce yourself and share your role and the roles of other partners
		Talk directly to the family members as well as the child
		Ask open-ended questions and engage families in responses
		Focus on family strengths
Goal 2. Plan and Make Decisions Collaboratively with Families	A. Support families in bringing in others to help guide and support their decisions	Help families identify those in their lives who provide support to them in various ways
		Provide open and safe spaces for families to bring in others to support them
		Respect and honor different perspectives on how families identify "family"
	B. Provide clear options for families and discuss competing priorities to make plan	Review options and help families understand the benefits and potential disadvantages of those various options
		Validate the family's preferences verbally and openly
		Use supportive, positive, and reassuring language to reinforce the family's choices
		Clearly communicate the purpose of follow up and use a variety of strategies to follow up with families, such as texting, phone calls, and asking for updates

ELEMENT 4. Assess Health

Assess Whole Family Health and Resilience

Goal 1. Understand Families' Assets and Risks	A. Partner with families to understand their family and community context	Honor cultures, beliefs, and family structures
		Normalize daily stressors
		Acknowledge child development as a stressor
	B. Use appropriate and effective tools that examine risks, needs, and protective factors	Map which social determinants may relate to developmental screenings already in practice as well as to whole family health and resilience
		Select tools that fit the clinic's culture and community
		Screen for "whole family health" and "whole family resilience"
		Develop clear expectations for how, when, and by whom the tool/questions are administered
		Introduce screening tools to families in family-friendly ways, e.g., preambles
Goal 2. Engage Families Using Information Learned	A. Use results to engage and partner with all families	Use appreciative inquiry techniques to learn more about the families' responses
		Focus on family strengths
		Use the questions to go deeper
		Identify and prioritize solutions and strategies together with the family

ELEMENT 5. Address Health

Address Whole Family Health and Resilience

Goal 1. Raise Awareness of Links between Trauma/Stress and Health	A. Share information with families about trauma, stress, health, resilience, and wellness	Share written materials about parenting in family-friendly language and in non-judgmental ways
		Provide reassurance by normalizing experiences and responses
	B. Guide families about how they can help support the child	Show fun, light, family-friendly videos in the waiting room about family strengths and positive parenting
		Offer parenting classes or programs in the office
Goal 2. Provide Support and Services at the Visit	A. Provide parenting and anticipatory / developmental guidance	Incorporate into regular well-child visit as universal
		Have community health worker engage in discussions with families about this guidance
	B. Provide in-office evidence-based interventions to families, including caregivers who may have experienced trauma	Identify key elements of EBPs that might be extracted and delivered in office in "small" doses
		Develop list / guidance for these EBPs
		Honor the families' feelings about help
Goal 3. Link Families to Services and Supports	A. Connect families directly to community partners to address their needs and support their health and wellness	Develop shared understanding of expertise
		Coordinate care in real time
		Bring partners "into the room"
	B. Connect families directly to specialty care, including evidence-based practices	Identify and develop list of key evidence-based practices to meet needs of the community
		Identify which evidence-based practices may be delivered in-office and train providers in these practices
		Directly connect families to providers of those evidence-based practices that cannot be delivered in-office

ELEMENT 6. Coordination

Coordinate Services and Supports for Families

Goal 1. Provide Coordinated, Integrated Care in the Community	A. Develop capacity in the community for community health workers	Partner with the community to understand who is already there who might play these roles in the office
		Be creative about the various possible roles the community health worker might play to support families
	B. Provide training, coaching, supervision, and support to community partners in their ongoing development and advancement	Explore tuition waivers for continuing education
		Develop career paths to avoid turnover
Goal 2. Provide Coordinated, Integrated Care Across and Within Systems	A. Improve processes for obtaining consent across specialists and systems	Integrate into routine paperwork
		Explain purpose of sharing information between providers to families
		Ensure consistency across providers
	B. Improve processes of working with other specialists and systems when patients are "shared"	Include communication/coordination protocols regarding needs, strengths, plans, services, progress, etc. within electronic records, patient portal, paper passport
		Use "warm handoffs"
		Make a clear plan for continued involvement
	C. Determine financing mechanisms to support coordination, communication, and partnership	Identify gaps in service provision
		Build on existing financing mechanisms, including behavioral health services, family-focused services, and medical homes
		Identify certification and possible billing mechanisms
		Create a business model to develop and sustain the financing