Maryland

GOVERNOR'S OFFICE OF CRIME PREVENTION, YOUTH, AND VICTIM SERVICES

Commission on Trauma-Informed Care: Findings and Recommendations on the Development and Implementation of an ACEs Aware Program 2023 Report

Human Services Article, § 8-1309(a)(2); Senate Bill 299/Chapter 723, 2021; House Bill 548/Chapter 722, 2021

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Acknowledgements

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Executive Summary

In accordance with Chapters 722 and 723 of 2021 (House Bill 548/Senate Bill 299), the Commission on Trauma-Informed Care (Commission) is charged to coordinate a statewide initiative to prioritize the trauma-responsive and trauma-informed delivery of State services that affect children, youth, families, and older adults.[1] In addition, and in consultation with the Maryland Department of Health, the Department of Human Services, and the Maryland Health Care Commission, the Commission must study and implement an Adverse Childhood Experiences (ACEs) Aware program.[2] The purpose of the ACEs Aware program is to screen for ACEs and toxic stress to provide targeted evidence-based interventions to support individual and family health. As part of the study, the Commission must (1) propose a process to set up training and an accreditation process for program providers and (2) explore the possibility of third-party reimbursement for screenings under the program. Furthermore, and in accordance with § 8-1309(b)(5) of the Human Services Act, the Commission must submit a report to the Governor and the General Assembly by October 1 of each year, as it relates to its findings and recommendations regarding the development and implementation of an ACEs Aware program.

Through its charge, and under the leadership of Chairwoman Christina Drushel Williams, and staff from the Governor's Office of Crime Prevention, Youth, and Victim Services, the Commission began developing a statewide strategy toward an organizational culture shift into a trauma-responsive state government, and a process and framework to implement an ACEs Aware program in the State.

To address its charge, the Commission formed the ACEs Aware Workgroup, co-chaired by Carrie Freshour and Jessica Lertora. The ACEs Aware Workgroup is supported by the following workgroups created by the Commission to address related focus areas:

- **Metrics & Assessment**: Chaired by Kay Connors, this workgroup focuses on developing metrics to be utilized to evaluate the progress of the statewide trauma-informed care initiative.
- **Training**: Chaired by Amie Myrick and Janie Goldwater, this workgroup focuses on the design and implementation of a statewide trauma-informed training to be provided to State agencies in coordination with the Maryland Department of Health.
- **Operational Implementation & Technical Assistance**: Chaired by Elizabeth Guroff, Dr. Inga James, and Dr. Michael Sinclair, this workgroup focuses on developing recommendations on trauma-informed policies and procedures for State agencies. In collaboration with the Maryland

[1] Maryland General Assembly. (2021). *Chapters 722 and 723 (House Bill 548/Senate Bill 299), Human Services - Trauma-Informed Care - Commission and Training (Healing Maryland's Trauma Act)*. https://mgaleg.maryland.gov/2021RS/chapters_noln/Ch_722_hb0548T.pdf; https://mgaleg.maryland.gov/2021RS/chapters_noln/Ch_723_sb0299T.pdf

[2] Maryland General Assembly. (2021). *Senate Bill 299 (2021), Human Services - Trauma-Informed Care - Commission and Training (Healing Maryland's Trauma Act) [Fiscal and Policy Note, Third Reader - Revised]*. https://mgaleg.maryland.gov/2021RS/fnotes/bil_0009/sb0299.pdf

Department of Health, the workgroup will provide technical assistance and guidance on implementing trauma-informed training and operational policy and procedure review.

- **Communication Strategies**: Chaired by Ulysses Archie, Jr. and Philip Leaf, this workgroup focuses on developing recommendations regarding a cross-agency and evidence-informed communications strategy that will support Maryland's statewide strategy toward an organizational culture shift into a trauma-responsive state government.
- **Definitions & Core Values**: Chaired by Cherry Price and Frank Kros, this workgroup focuses on developing standardized definitions so that the State, across agencies, is using consistent language in legislation, policies, public awareness campaigns, grant applications, training, etc. The group also identified equity as a core value that needs to be present throughout the work of the Commission and its workgroups.

Pursuant to § 8-1309(b)(5) of the Human Services Act, this *Commission on Trauma-Informed Care: Findings and Recommendations on the Development and Implementation on the Adverse Childhood Experiences (ACEs) Aware Program 2023 Report* includes information on the findings and recommendations of the Commission as it relates to the trauma-responsive and trauma-informed delivery of State services that affect children, youth, families, and older adults. It also provides recommendations to improve existing laws relating to children, youth, families, and older adults in the State.

Adverse Childhood Experiences (ACEs) Aware Program

I. Study Developing a Process and Framework for Implementing the Program

In consultation with the Maryland Department of Health, the Department of Human Services, and the Maryland Health Care Commission, the Commission on Trauma-Informed Care must study developing a process and framework for implementing an ACEs Aware program in Maryland and implement the program. The purpose of the program is to screen for adverse childhood experiences and toxic stress to provide targeted evidence-based interventions to support individual and family health, in order to improve individual and family well-being and reduce health care costs.

In January of 2022, the Commission created the ACEs Aware Workgroup as well as several related workgroups, which include membership from local community members, to accomplish its goals.

A. ACEs Aware Workgroup

The ACEs Aware Workgroup defined its purpose in the following way: "The ACEs Aware workgroup is to study the ACEs Aware California program, evaluate it as a potential model to be replicated (in whole or part) in Maryland, and ensuring the recommended model includes resources, treatment, and support that are both evidence-based and cost-effective, supporting individual and family health in Maryland."

To achieve this, the workgroup will:

- Review the original ACE study for context and history;
- Research other states that participate in ACEs-Aware;
- Research Safe Environment for Every Kid (SEEK) and other evidence-based practices and models that meet the intended purpose; and
- Assess the budgetary requirements needed to establish and implement a program model that meets the intended needs by screening for ACEs and other toxic stress.

The ACEs Aware Workgroup is made up of over 40 individuals including a legislator, government agency representatives, community representatives, pediatricians, advocates, researchers, therapists, and more. The workgroup continues to meet regularly in an effort to create a framework for an ACEs Aware program for Maryland. A brief description of its progress during meetings is as follows:

August 2022 - November 2022

The workgroup reviewed the ACEs Aware California Model documents and studies including the Roadmap, Implementation Mapping tools provided by Dr. Christina Bethell, and protocols supporting the implementation of a state policy on screening for ACEs in a system of health centers in inland Southern California. The co-chairs of the workgroup created a feedback form for committee members to assess the ACEs Aware California Model. In partnership with Dr. Bethell, the co-chairs also reached out to the California Aware developers, who served on the original program development team in California. In addition, the co-chairs reached out to professionals regarding similar programs. As a result of these efforts, Dr. Howard Dubowitz presented to the workgroup on the SEEK model.

December 2022 - February 2023

The co-chairs created an additional form for workgroup members to submit reviews of similar model programs. Workgroup members were also provided with literature for review and discussion at meetings. Kelly Cible, Director of Maryland Behavioral Health Integration into Pediatric Primary Care **(**BHIPP), presented an implementation model that involved integrating social workers into medical practices to conduct screenings, linkages, and referral through warm handoffs. Amie Myrick, an ACEs Interface Master Presenter, delivered a presentation on the HOPE program.

March 2023 - May 2023

The workgroup met to review the responses provided by California. The conversation proved challenging because it was unclear if the co-chairs had permission to share the written responses with the workgroup. The group concluded that additional information was needed to fully understand the written responses. Dr. Wendy Lane presented on ACEs Aware Screening and SEEK from the perspective of a pediatrician. Dr. Lane, an expert General Pediatrics, Child Abuse Pediatrics, and Preventative Medicine, emphasized the importance of considering social determinants of health (SHD) in screening

and the need for warm handoffs to support families effectively. Dr. James Yoe presented on model recommendations and the current Behavioral Health Administration, Maryland Department of Health, and University of Maryland School of Medicine initiatives for ACE efforts in Maryland. The need for support and resources to be available after screening continues to be a concern for the group. The group also discussed the need to learn about alternative screening tools.

June 2023 - August 2023

The workgroup continues to invite presentations from Maryland professionals in an effort to study similar successful programs in Maryland to inform future decision making regarding an ACEs Aware program for Maryland. A subset of workgroup members, along with the Co-Chairs is meeting with the representative from CA in order to plan for future presentations and discussions with them.

B. California's ACEs Aware Program

The ACEs Aware Workgroup studied California's ACEs Aware Program,[3] to include the following objectives for its program:

1. To inform and empower primary care clinicians with the latest evidence on how to recognize, address, and prevent ACEs and toxic stress.
2. To incentivize early detection and early intervention for toxic stress by reimbursing providers for screening for ACEs, which involves assessing for the triad of adversity (ACE score), clinical manifestations of toxic stress (ACE-Associated Health Conditions), and protective factors to assess clinical risk for toxic stress and to guide effective responses.
3. To increase awareness and utilization of cross-sectoral, evidence-based clinical and community interventions for preventing and mitigating the toxic stress response.
4. To build clinical capacity for screening for, and responding to, ACEs and toxic stress by investing in the development of clinical protocols and community networks for response.
5. To improve clinical outcomes and health equity by enhancing the quality and specificity of health care provided to individuals exposed to ACEs and/or at risk for toxic stress, through rigorous, evidence-informed methods.

California's ACEs Aware Initiative was implemented in three phases (*as described below*).

The first phase focused on initial training of providers. This free two-hour online training, titled *Becoming ACEs Aware in California*, was adapted from a trauma-informed care curriculum developed by the Office of Women's Health of the U.S. Department of Health and Human Services. The training covered three topics: 1) clinical algorithms to assess for and respond to risk of toxic stress, including

[3] Bhushan, D., Kotz, K., McCall, .J, Wirtz, S., Gilgoff, R., Dube, S.R., Powers, C., Olson-Morgan, J., Galeste, M., Patterson. K., Harris, L., Mills, A., Bethell, C., & Burke Harris, N. (2020). *Roadmap for Resilience: The California Surgeon General's Report on Adverse Childhood Experiences, Toxic Stress, and Health*. Office of the California Surgeon General. DOI: 10.48019/PEAM8812

formulating appropriately tailored, strengths-oriented, and evidence-based treatment plans; 2) about two screening tools required for reimbursement; and 3) information on obtaining reimbursement for ACE screening of California's medical assistance program.

The second phase of the initiative focused on strengthening provider engagement and capacity. California funded grants for provider training, provider engagement, and communications. The state partnered with Frameworks Institute to work with grant recipients to build capacity, offer technical support, and develop consistent and effective messaging on ACEs and toxic stress that is grounded in the latest science. The provider training grants were designed to deepen the ACEs Aware Core Training Certification criteria and created supplemental training to augment the information provided in the Core training. The provider engagement grants were designed to create opportunities for providers to interact with each other and with other stakeholders to share lessons learned and best practices specific to geographic areas, patient populations, provider types, and practice settings. The communication grants were designed to create strategic communication efforts to disseminate information on provider training and engagement opportunities.

In a second round of grants, ACEs Aware provided funding for Network of Care grants which were designed to create connections between medical assistance providers, social service systems, and community partners to assure that toxic stress in children and adults is addressed properly through clinical and community interventions following an ACE screening, to prevent future ACEs, toxic stress, and intergenerational transmission, and prevent or assist in treating ACEs Associated Health Conditions (AAHCs). These grants were divided into planning and implementation grants.

In addition to the grants, ACEs Aware invested in provider engagement through monthly webinars and external stakeholder engagement. The monthly webinar promoted ongoing practice improvement and clinical implementation learnings among California providers. The external stakeholder engagement occurred through the Trauma-Informed Primary Care Implementation Advisory Committee (TIPC). The TIPC advises ACEs Aware on promising models, best practices, clinical systems, policy expertise, strategic insights, and the latest science. The TIPC created subcommittees to address specific goals of the TIPC.

Finally, ACEs Aware coordinated with managed care plans (MCPs) to enlist their partnership in engaging providers in screening for ACEs and toxic stress.

The third phase of California's ACEs Aware program is quality improvement. The main mechanism is the California ACEs Learning and Quality Improvement Collaborative (CALQIC) which will generate both qualitative and quantitative data on best practices in ACEs screening and response from 53 clinics in seven California regions over 18 months.

The 53 learning collaborative clinics were provided with virtual coaching and technical assistance, grants, and virtual site visits to exemplary organizations. The clinics will integrate equity and patient/community voice into all aspects and activities of the project team, participating clinicians will

be trained, and best practices for the training of health care providers will be developed. Finally, the QI team will be collecting data to identify and respond to any potential adverse events associated with ACEs screening.

C. ACEs Aware Workgroup ~ Collaborating with California's ACEs Aware Program

With the guidance and assistance of Dr. Bethell, the ACEs Aware Workgroup continued to build a relationship with representatives from the California ACEs Aware Program. Following the initial assessment of the California program, the workgroup created a list of eleven questions for the UCLA-UCSF ACEs Aware Family Resilience Network (UCAAN) - a multi-campus University of California initiative that implements ACEs Aware on behalf of the California Department of Health Care Services - to provide insight on the background and history of the initiative. The eleven questions included the following:

1. What were the main objectives for the ACEs Aware program as they relate to government agencies/providers and community?
2. What has gone well and why? What advice do you have for Maryland?
3. What do you think has not gone as well as expected and why? What advice do you have for Maryland?
4. How has the original design changed from origination, and why did it change? What is the result of those changes?
5. How have resources and capacity been built to support the ACEs Aware effort as it has evolved from the initial work? What key learnings might you share as Maryland advances its work?
6. How did you come up with the initial budget? Lessons learned from that? Needs realized since initial budgeting? Did you budget first and then design the work or vice-versa - in other words, did you have a set amount to work with/capped or did you create a budget and secure the funding based on the plan?
7. Have you used funding approaches that leverage existing resources and advance integration of resources across state agencies (Medicaid/CHIP, Early Care/Education, EI, CPS, Title V, home visiting, AHECs, etc.) and other California partners (county health departments, FQHCs, health plans, family and community organizations, etc.)?
8. California is diverse and large; how did you implement it in diverse rural and urban settings: If this is laid out in the roadmap or other reports, please share where we might find these. It seems that UCAAN is organized to address Southern (UCLA) and Northern California (UCSF). If this is correct, are the approaches similar and is the goal to focus on implementation and evaluation based on existing approaches or to rethink approaches based on real-time learning?
9. In addition to what is laid out in the roadmap document, might you share more about how you looked at prevention infrastructures to mitigate the ACEs overall? How did you arrive at this approach in the development process of the California model?

10. A lot of data and science was included in the roadmap report. In addition to new data analysis using the Behavioral Risk Factor Surveillance System (BRFSS) and California data from the National Survey of Children's Health (NSCH) that was presented, were additional and more current analyses conducted? If so, what occurred to make this happen?
11. In terms of the science and data used to advance the work in California, what did you find to be most important as it relates to, for example, neurotoxicity and key data elements in the science? What findings or data elements were most essential as you advanced and shaped the ACEs Aware model and work?

The workgroup received written responses from California and are making arrangements for its representatives to attend an ACEs Aware Workgroup meeting in September/October 2023, to discuss the responses and ask additional questions. The workgroup appreciates the assistance of Dr. Bethell and the California team as it seeks to fully understand the ACEs Aware program.

D. ACEs Aware Workgroup ~ Review of Additional Models

The Workgroup is diligently crafting a comprehensive list of relevant programs/models while also engaging speakers to gain insights from Maryland initiatives, aligning with our pursuit to develop recommendations for an impactful ACEs Aware program for Maryland. The group also invited speakers to provide additional information about programs in Maryland to inform the workgroup as they consider the elements to include in an ACEs Aware program for Maryland. In response to this invitation, the workgroup received additional information on the following three programs:

Safe Environment for Every Kid (SEEK) Model

Dr. Howard Dubowitz presented to the workgroup on the SEEK model of primary care. SEEK is a practical and evidence-based approach that helps primary care pediatricians address targeted social determinants of health or ACEs that are also risk factors for child maltreatment, parental depression, major stress, substance use, intimate partner (or domestic) violence, food insecurity, and harsh punishment. SEEK enhances primary care by promoting the healthy functioning of children, parents, and families. It is easy to implement, and the screening may be reimbursed.

SEEK was developed to take advantage of excellent opportunities in primary health care to learn about children's family environments and to facilitate help when needed. A practical approach was developed to help primary health care professionals play this role. Based on two randomized controlled trials, the SEEK approach yielded promising findings toward helping prevent child maltreatment.[4] SEEK helps to respond to the potential long-term and substantial harm associated with childhood adversities. It also helps with increasing recognition of the important need to address social determinants of health.

Maryland Behavioral Health Integration in Pediatric Primary Care (BHIPP)

[4] The SEEK Project, LLC. (2023). *Evaluating SEEK*. https://seekwellbeing.org/evaluating-seek/

Kelly Coble presented to the workgroup on the BHIPP model, a program that successfully integrates behavioral health into pediatric primary care and emergency medicine settings. The goal of this program is to assess and manage the mental health needs of patients from infancy through the transition to young-adulthood through the following services:[5]

- Consultation Warmline: Child mental health specialists provide behavioral health consultation on a range of subjects.
- Training and Education: BHIPP offers numerous training and educational opportunities to pediatricians and emergency medicine professionals.
- Telepsychiatry Access Program (TAP): This provides telemental health services such telepsychiatry, telecounseling, and care coordination.
- Social Work Co-location: BHIPP provides social work co-location in primary care settings.

Although BHIPP is successfully linking 60% of its cases to services, it is also challenged by the volume of screenings and issues with reimbursement.

Healthy Outcomes and Positive Experiences (HOPE)

Amie Myrick presented the HOPE program to the workgroup. The HOPE program combines a public health approach to preventing child abuse with a broader understanding of how children grow to become strong, healthy, and resilient adults.[6] The program pulls together existing data and provides a common language to describe the kinds of experiences that counteract effects of adverse experiences and promote healthy development. The four building blocks of HOPE are composed of Positive Childhood Experiences (PCEs) and the sources of those experiences and opportunities that help children grow into healthy, resilient adults. Those four building blocks are: (1) relationships; (2) safe, equitable, and stable environments; (3) social and civic engagement; and (4) emotional growth. This program implementation model has similar intentions to span screening and education and awareness between provider and community. This program is similar to the Oregon model the Workgroup has been reading about.

E. ACEs Aware Workgroup - Next Steps

Over the upcoming year, the Workgroup will systematically analyze data from literature reviews, research, and consultations with experts like Dr. Robert Anda and California counterparts, aiming to gain deeper insights into the intricate aspects of funding, infrastructure, awareness, systemic implementation and progressing towards our goal. The ACEs Aware Workgroup invited Dr. Robert Anda to present to the Commission at the August 2023 meeting. The workgroup also scheduled a follow-up discussion with the California representatives to learn about their experience with implementing the ACEs Aware program for their residents. Additional speakers were also invited to

[5] Maryland Behavioral Health Integration in Pediatric Primary Care. Welcome. https://mdbhipp.org/
[6] Healthy Outcomes from Positive Experiences. History: A History of Hope. https://positiveexperience.org/about-us/history/

future meetings to study similar programs in Maryland and nationally. Workgroup members will continue to review literature for best practices in screening and addressing ACEs.

The ACEs Aware Workgroup is committed to partnering with State agencies and other workgroups of the Commission in the creation of an ACEs Aware program for Maryland. The workgroup communicates with these entities and will have representation from each in the near future. In addition, the group continues to reach out to pediatricians and other providers and community representatives to assure that the workgroup has a diverse representation of stakeholders and partners. In January 2023, the Carrie Freshour, Co-Chair, presented to the Maryland State Council on Child Abuse and Neglect (SCANN) in an effort to collaborate with other physicians and other medical providers, providing an update to the current workgroup efforts around ACE Aware programming.

Maryland Department of Human Services (DHS)

Through the Integrated Practice Model, the DHS Social Service Administration's (SSA) vision is to transform the social service system in partnership with public agencies, private agencies, courts, and community partners, so that the children, youth, families, and vulnerable adults are:

- Safe and free from maltreatment;
- Living in safe, supportive, and stable families where they can grow and thrive;
- Healthy and resilient with lasting family connections;
- Able to access a full array of high-quality services and supports that are designed to meet their needs; and
- Partnered with safe, engaged, and well-prepared professionals that effectively collaborate with individuals and families to achieve positive and lasting results.

DHS/SSA's ongoing strategies for accomplishing these goals are to:

- Promote safe, reliable, and effective practice through a strength-based, trauma-responsive practice model for child welfare and adult services.
- Engage in a collaborative assessment process that is trauma-informed, culturally responsive, and inclusive of formal and informal family and community partners.
- Expand and align the array of services, resources, and evidence-based interventions available across child welfare and adult services based upon the assessed needs of children, families, and vulnerable adults, to include additional resources aimed at preventing maltreatment and unnecessary out-of-home placements.
- Invest in a safe, engaged, and well-prepared professional workforce through training and other professional development, including strong supervision and coaching.
- Modernize DHS/SSA's information technology to ensure timely access to data and greater focus on agency, individual, and family outcomes.

- Strengthen the State and local continuous quality improvement processes by creating useful data resources to monitor performance, using evidence to develop performance improvement strategies, and meaningfully engaging internal and external stakeholders.

Similar to the ACEs Aware Program in California, Maryland is committed to continued partnerships between DHS/SSA and providers and community partners. In the same way that California provided Network of Care grants, Maryland could benefit from funding to build relationships between Maryland Medicaid providers and public and private community partners to assure that toxic stress in children and adults is addressed properly through clinical and community interventions following an ACE screening, to prevent future ACEs, toxic stress, and intergenerational transmission, and prevent or assist in treating AAHCs.

Moving forward, the Child Welfare Medical Director at DHS will be invited to the ACEs Aware Workgroup meetings to assure that DHS involvement is built into the ACEs Aware program plan for Maryland from the beginning.

Maryland Health Care Commission (MHCC)

MHCC is an independent regulatory agency whose mission is to plan for health system needs, promote informed decision-making, increase accountability and improve access in a rapidly changing healthcare environment by providing timely and accurate information on availability, cost, and quality of services to policy makers, purchasers, providers, and the public. The MHCC will work with the ACEs Aware Workgroup to create a plan for Maryland and will provide data, specifically data related to social determinants of health, that will inform decisions. Moving forward, the Director of Policy Development and External Affairs will attend the ACEs Aware Workgroup meetings to ensure that MHCC involvement is built into the ACEs Aware program plan for Maryland from the beginning.

II. Establish Training and An Accreditation Process

The Commission on Trauma-Informed Care will propose a process to establish training and an accreditation process for providers in the program. The ACEs Aware Workgroup agreed that training providers is a vital element that must be included in a program plan for Maryland. The workgroup is looking to the Maryland Department of Health (MDH), the Training Workgroup, the Core Values and Definitions Workgroup, and the Metrics and Assessment Workgroup to develop the specifics of Maryland's training program. Additionally, in researching accredited training for physicians, the ACEs Aware Workgroup reached out to MedChi as a potential partner. If the workgroup expands this training to include providers in other professions, the accredited training process will be different. The workgroup will continue to research this as the program develops further.

Maryland Department of Health

In July 2022, the Behavioral Health Administration (BHA) contracted with the University of Maryland School of Medicine in partnership with Bowie State University (together the "University Partnership") to lead the implementation of the ACEs Behavioral Health Data-to-Action Initiative, currently known as the Behavioral Health Building Healing Systems Initiative (BHBHS). The BHBHS includes three components: (1) building system capacity to use data to align services with best practices and the needs of communities; (2) a user-friendly Trauma-Informed Organizational Assessment (TIOA); and (3) tailored training and technical assistance to support public behavioral health system leaders in aligning services with best practices in trauma-informed organizational policies and practices. The University Partnership works closely with the Commission and its workgroups to assure the work is aligned.

The Building Healing Systems Data to Action Toolkit will be a website that introduces leaders in behavioral health and related service areas to the importance of shifting systems to be trauma-informed, resilience-oriented, and equitable, provides national and state level data to guide them in their work, and links data to concrete action steps they can take to help their team do work that will address the impact of ACEs and trauma and provide the resources needed to reduce ACEs, especially in communities that are disproportionately impacted. Final content including an introduction to trauma, ACEs, trauma-informed care and culture, healing-centered engagement, anti-racism, and secondary traumatic stress has been drafted and submitted to a software developer for organization on a website that will be available in July 2023.

MDH and the University of Maryland, in collaboration with the workgroups of the Commission, are working to address the three core activities:

- ACEs data collection, analysis, and data to action activities to increase awareness of ACEs and trauma-informed approaches to service delivery among State and local behavioral health partners;
- Identification and implementation of trauma-informed organizational assessment tool and continuous improvement/technical assistance process for use within MDH-BHA, local behavioral health partners, and public behavioral health system (PBHS) providers; and
- Selection, adaptation, and implementation of a trauma-informed training curriculum targeted to PBHS behavioral health partners and providers, and implemented statewide.

While the primary focus of the University's work is targeted to PBHS behavioral health partners and providers, the University and MDH are open to expanding the focus, where feasible, to meet the goals of the Commission. In addition, and in partnership with the workgroups listed below, the University and MDH will work to develop a program for Maryland. The BHA is partnering with Frameworks Institute on behalf of the Commission to create the BHA TIROE Knowledge Mobilization Grant Project. This project was presented to the Commission at the April meeting and the Commissioners voted to approve the partnership. The TIROE Knowledge Mobilization Project will utilize communication science for strategic framing and knowledge mobilization to further the work of programs within BHA as well as

support the work of the Commission to create a culture shift toward a TIROE within the State government.

Training Workgroup

Under the leadership Ms. Amie Myrick and Ms. Janice Goldwater, the Training Workgroup meets each month to discuss training curricula and topics to be included in trauma-informed care training. The group created a powerpoint slide deck based on the Commission's approved training objectives. The workgroup is currently working with Frameworks Institute to create a training plan for the Commission. Once the ACEs Aware Workgroup is ready to create training for providers, the two workgroups, in partnership with Frameworks Institute, will plan effective training based on the needs of the intended audience.

Definitions & Core Values Workgroup

In 2023, the Definitions & Core Values Workgroup, Chaired by Cherry Price and Frank Kros, met several times and gathered definitions of national organizations for specific terms identified by the Commission and the workgroup. The workgroup also reviewed the definitions submitted within the agency reports. Following the Commission's Visioning Retreat, the workgroup continues to develop a set of unified definitions to be reviewed by the Commission and recommended for use across state agencies. These definitions will be utilized in the work of the ACEs Aware Workgroup as well in the creation of Maryland's program.

Metrics & Assessment Workgroup

The Metrics & Assessment Workgroup, chaired by Kay Conners, meets each month to discuss the development of metrics to be used to evaluate the progress of the statewide trauma-informed care initiative. The group assembled a database of assessment tools, materials, and recommendations for the Commission. As the work of the ACEs Aware Workgroup moves forward, and begins considering specific assessment tools, the partnership with the experts in the Metrics & Assessment Workgroup will be crucial.

Accredited Training Partnership

The ACEs Aware Workgroup is committed to assuring that CME/CEUs are provided with any training for providers. In a meeting with MedChi, an accredited provider of CMEs in Maryland, it was determined that physicians are required to renew their medical license every two years, and during those two years are expected to accumulate 50 CMEs to maintain their license. These CMEs must be achieved by attending training that is conducted in partnership with an accredited provider such as MedChi, University of Maryland, Johns Hopkins University, etc. In order for a training to qualify for CMEs, it must comply with the requirements set by the American Medical Association (AMA) and the Accreditation Council for Continuing Medical Education (ACCME), to include: (1) meet a need and/or

fill a gap/problem in practice; (2) utilize adult learning practices; (3) be conducted by a trainer/speaker that is a subject matter expert; (4) include an evaluation that accurately assesses the learning of the subject matter covered in the training; and (5) be free of commercial bias or influence.

While it may be important to train providers with different professional certifications, CMEs typically are the most difficult to receive approval. Once the workgroup creates a full training, and the audiences have been established, the CEU applications for all professions targeted will be completed.

III. Explore the Possibility of Third-Party Reimbursement

On July 14, 2010, the Departments of Health and Human Services, Labor, and the Treasury issued new regulations, building on the Affordable Care Act, requiring private health plans to cover evidence-based preventive services and to eliminate cost-sharing for preventive care.[7] "For new health policies beginning on or after September 23, 2010, preventive services that have strong scientific evidence of their health benefits must be covered and plans can no longer charge a patient a copayment, coinsurance or deductible for these services when they are delivered by a network provider."[8]

Maryland should follow California's lead and take advantage of this opportunity to leverage the child and adult well visit benefit in both Medicaid, Medicare, and private insurance. Since all health plans are required by law to provide services aligned with Bright Futures Guidelines, this makes this a high leverage opportunity. The goal would be to utilize an evidence-based approach to conduct whole child/whole family assessments (whichever the workgroup and Commission decides is most appropriate) that build trust and partnership between providers and children/families.

In an effort to explore the possibility of third-party reimbursement, including the State Medical Assistance program, for screenings under the program, the ACEs Aware Workgroup reached out to MDH, Maryland Medical Assistance (Medicaid). Maryland Medicaid currently reimburses, or is planning to reimburse, for services in multiple maternal and child health (MCH) programs. While these programs are not specifically focused on ACEs screenings, they address ACEs by supporting both parents and children in all aspects of health. The three MCH programs outlined below aim to prevent and/or address adverse childhood experiences.

1. **Healthy Steps**, a program of ZERO TO THREE, is a pediatric primary care model that promotes positive parenting and health development for babies and toddlers. Under the model, all children ages zero to three and their families are screened by a child development expert, serving in the role of the Healthy Steps Specialist, and placed into a tiered model of services of risk-stratified supports.
2. **Home Visiting Services (HVS)** in early childhood was established in January 2022, and is a

[7] U.S. Centers for Medicare & Medicaid Services. (2010). *Background: The Affordable Care Act's New Rules on Preventive Care*. https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/preventive-care-background
[8] Ibid.

statewide benefit for Medicaid beneficiaries, including the Healthy Families America (HFA) and Nurse Family Partnership (NFP) models. Both models employ specific developmental and depression screenings and have an established track record of improving the health and well-being of both the birthing parent and the child.

3. **Maternal Opioid Misuse (MOM) Model** was launched in January 2020. This multi-prong approach aims to improve maternal and infant health outcomes through a number of targeted initiatives. While the focus of the intervention is on the parent, the MOM intake process incorporates a variety of screenings. The health-related social needs assessment includes questions related to safety. While there is no ACEs specific screening conducted, a variety of questions are related to ACEs and toxic stress, predominantly regarding abuse.
4. The federally required **Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program** provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. The comprehensive benefit aims to ensure that children receive critical screening, preventative services, and treatment services to prevent future medical issues. Program components include preventative, dental, mental health, and developmental services, as well as other speciality services. In Maryland, the preventative care component of the EPSDT program is known as the Healthy Kids Program.

The Maryland Medicaid program does not currently reimburse providers for ACEs screenings. To implement coverage for this benefit for both children and adults, a budget initiative would be required. In addition, Maryland would need to amend its State plan and regulations, as well as incorporate the benefit into the HealthChoice managed care organization rate setting process. System changes would also be required to allow accredited/credentialed providers to bill Medicaid for the ACEs screening. The complete description of Maryland Medicaid ACEs Related Reimbursement is included in **Appendix 1**.

IV. Implementation of the Program

The Commission continues to study the ACEs Aware program and develop a framework for implementing an ACEs Aware program in Maryland. The Commission is not prepared to propose implementing a program at this time. Because of this, the Commission and the ACEs Aware Workgroup will continue to partner with the following workgroups to further its efforts.

Operational Implementation & Technical Assistance Workgroup

Under the leadership of Elizabeth Guroff, Inga James, and Michael Sinclair, the Operational Implementation & Technical Assistance Workgroup met several times to discuss the design and implementation of a statewide trauma-informed training. The workgroup also created *The Maryland Way: Trauma-Informed, Resilience-Oriented, Equitable Care and Culture (TIROE)*, a document which is adapted from the Principles of Trauma-Informed Care and 10 Implementation Domains offered by

SAMHSA.[9] This document was adopted by the Commission and currently serves as a guide for the Commission's work moving forward. Once the ACEs Aware Workgroup is prepared to begin planning for implementation and technical assistance of Maryland's program, the Operational Implementation & Technical Assistance Workgroup will partner with them to ensure the timely implementation of the program. This document is included in **Appendix 2.**

Communication Strategies Workgroup

The Communication Strategies Workgroup, chaired by Ulysses Archie, Jr. and Phil Leaf, met bi-weekly with members representing academic, governmental, healthcare, early childhood agencies, and community stakeholders to discuss components of an effective communication strategy to support an organizational culture shift into a trauma-responsive government. The workgroup also identified and began examining jurisdictional examples of the use of a two-science approach, applying communication science to the science underlying trauma (neurobiology, epigenetics, ACEs/trauma, resilience). A two-science approach supports the translation of scientific knowledge into metaphors that are easy for non-scientists to understand, and disseminates that knowledge broadly in a common unified language through public announcements, speeches, events, training curricula, tools, policies, practices, contracts, notices of funding, and across a range of media. This process of making the scientific information underlying trauma broadly accessible is called knowledge mobilization, and its goal is to shift conversations, catalyze change, support strong brain architecture, good mental health for children and families, and prevention and mitigation of trauma. The workgroup is also examining what message needs to be communicated to shift the culture and practices of agencies to become trauma-informed and trauma-responsive. As the ACEs Aware Workgroup begins to think about raising public awareness regarding Maryland's program, the Community Strategies Workgroup will assist in creating and communicating messages to providers and then the community.

V. Findings and Recommendations

At this time, the Commission is not prepared to make final recommendations regarding the implementation of an ACEs Aware program in Maryland. The ACEs Aware Workgroup is diligently working to investigate this matter and propose recommendations to the Commission. The themes that have consensus with the workgroup thus far are as follows.

A. Necessary Financial Investment

In all the research thus far, the need for significant funding to implement a program similar to the ACEs Aware Program in California remains inevitable. In reviewing the surgeon general's report, it is evident that California's program required incredible investment from the state. The report does not include a

[9] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA). (2014). *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach*. Retrieved from https://store.samhsa.gov/sites/default/files/d7/priv/sma14-4884.pdf.

budget for the first phase in which the provider training and Medicaid reimbursement occurred, however, it is certain that it required an initial financial investment. The report does state that in phase two, $14.3 million in grants were provided. A second round of grants were distributed up to $30 million in Network of Care Grants. The final stage consisted of a partnership between the state, a university, and a private corporation so it is unclear what the financial commitment of the state was; however, considering the extent of an 18 month project providing training and technical assistance and conducting intense evaluation of 53 community clinics, the budget is presumed to be extensive. The workgroup is confident that future collaborative conversations with the California representatives will provide a clearer view of budgetary requirements.

B. Certified Training for Providers

Similar to the California program, Maryland is committed to providing quality training to providers. In order to provide such training, the Commission will require financial resources. While the Commission and the community members working diligently on the workgroups are passionate and willing to donate their time to this work, the extent of this task will require hiring a contractor or providing community grants to provide training on this scale. The group believes that training providers will be beneficial in Maryland, especially if accredited CME/CEUs can be provided. This training should be broader than simply explaining an assessment tool but rather include a coaching model or in some way enable providers to play this new role competently.

The workgroup is encouraged by California's community involvement model and the partnership with the Frameworks Institute for public awareness. Incorporation of the community, and specifically that of individuals with lived experiences, assures that the program remains vital and responsive to the needs of those it serves. Public awareness strategies employed by the Frameworks Institute are the model that the Commission's Community Strategies Workgroup feel will be most beneficial in Maryland.

C. Third-Party Reimbursement for Medicaid Providers

Similar to the program in California, Maryland will need to include third-party reimbursement for providers providing assessments. In order to implement coverage for this benefit for both children and adults, a budget initiative would be required. In addition, Maryland will need to amend its State plan and regulations, as well as incorporate the benefit into the HealthChoice managed care organization rate setting process. System changes would also be required to allow accredited/credentialed providers to bill Medicaid for the ACEs screening. The group believes that enabling providers to receive third-party reimbursement for the additional time that it will take to conduct assessment thoroughly will be crucial. This partnership with Maryland Medicaid and potentially other managed care organizations (MCOs) will prove to be pivotal moving forward.

D. Further Research Regarding Assessment Tool

The ACEs Aware Workgroup has concerns about utilizing the ACEs tool as an assessment tool given it was never intended to be utilized in this way. The original ACEs study was an epidemiological study designed to look at ACEs across a population. The ACEs survey can assist a provider in understanding an individual's history, however, it is not a diagnostic tool. Although the workgroup is not opposed to an assessment in general, it is looking at other assessment tools, such as the PEARLS tool (currently used in California) and other tools that look at ACEs in addition to social determinants of health, positive childhood experiences, and resiliency.

E. Warm Hand-Off Supports

The workgroup feels strongly that any program that screens for ACEs, PACEs, and SDH needs to include a warm hand-off to available resources to effectively support Maryland children and families. The workgroup has consistently expressed concerns about beginning a program of assessment when Maryland is currently lacking resources to treat the extent of trauma in its community. The workgroup is interested in working with the Operational Implementation & Technical Assistance Workgroup to assure that this need is being addressed. The group is also conducting a survey to assess the level of services that currently exist in communities statewide. Additionally, the group has expressed the critical need for the continued allocation of resources to support both the assessment and the implementation of the program.

F. Include Prevention Programming

Finally, the workgroup wants to ensure that a program created for Maryland has an element of prevention, not just identification and treatment. Ideally, the program will reach children, families, and communities in a way that prevents ACEs from occurring in children's lives. The workgroup intends to target efforts at prevention in state agencies and communities. Addressing PCEs is especially important in the prevention of and treatment for ACEs.

G. Network of Care Investment

Similar to the program in California, Maryland is committed to continued partnerships between DHS/SSA and providers and community partners. In the same way that California provided Network of Care grants, Maryland will benefit from funding to build relationships between Maryland Medicaid providers, local social service systems, and community partners to assure that toxic stress in children and adults is addressed properly through clinical and community interventions following an ACE screening, to prevent future ACEs, toxic stress, and intergenerational transmission, and prevent or assist in treating AAHCs.

Conclusion

In accordance with Chapters 722 and 723 of 2021, the Commission will continue to coordinate a statewide initiative to prioritize the trauma-responsive and trauma-informed delivery of State services that affect children, youth, families, and older adults; and report its findings and recommendations to the Governor and the General Assembly by October 1 of each year, as it relates to the development and implementation of the ACEs Aware program in Maryland.

Appendix 1: Maryland Medicaid and ACEs Screening

Maryland Medicaid and ACEs Screening

In response to a request made by the Commission on Trauma-Informed Care in regard to the report mandated by § 8-1309(b) of the Human Service Article, entitled, "Commission on Trauma-Informed-Care: Findings and Recommendations on the Development and Implementation of the Adverse Childhood Experiences (ACEs) Aware Program," the Maryland Medical Assistance program (Medicaid) would like to share the following information on ACEs screening and the Medicaid program.

Maternal and Child Health Programs that Address ACEs

Maryland Medicaid currently reimburses, or is planning to reimburse, for services in multiple maternal and child health (MCH) programs. While these programs are not specifically focused on ACEs screenings, they address ACEs by supporting both parents and children in all aspects of health. The three MCH programs outlined below all aim to prevent and/or address adverse childhood experiences.

HealthySteps

HealthySteps, a program of ZERO TO THREE, is a pediatric primary care model that promotes positive parenting and healthy development for babies and toddlers. Under the model, all children ages zero to three and their families are screened by a child development expert, serving in the role of HealthySteps Specialist, and placed into a tiered model of services of risk-stratified supports. Supports include care coordination and on-site intervention. The HealthySteps Specialist joins the pediatric primary care team to ensure universal screening, provide successful interventions, referrals and follow-up to the whole family.

While ZERO TO THREE does not require ACEs screening, the HealthySteps screening schedule recommends a parent ACEs screening at newborn visits. Additionally, the overall approach of placing children and their families into risk-stratified tiers enables the practice to support each child and family on an individualized basis. HealthySteps providers screen for maternal depression, food insecurity, housing instability, interpersonal safety, among other screenings. Practices may implement additional screenings, including ACEs screenings, if resources are available and staff is appropriately trained.

The HealthySteps national website also has a resource page dedicated to ACEs to support practices in identifying ACEs. The national body estimates that 30% of HealthySteps practices screen for ACEs at this time.

Maryland Medicaid will begin providing enhanced payments to HealthySteps providers January 1, 2023. Additional information can be found on the MDH HealthySteps webpage once coverage is effective.

Home Visiting Services (HVS)

In 2017 MDH established a Medicaid HVS Pilot to test a service expansion initiative for home visiting services in Maryland. This pilot tested two evidence-based home visiting models, Healthy Families America (HFA) and Nurse Family Partnership (NFP). Beginning in January 2022, Maryland established early childhood home visiting, including the HFA and NFP models, as a statewide benefit for Medicaid beneficiaries. Both models employ specific developmental and depression screenings and have an established track record of improving the health and well-being of both the birthing parent and the child. With factors such as single parenthood, low income, childhood history of abuse, substance use disorder (SUD), mental health issues or domestic violence having a significant impact in the health of the parent-child dyad, this benefit aims to encourage a positive parent-child relationship and maternal, child and family accomplishments.

Maternal Opioid Misuse (MOM) Model

Maryland Medicaid launched its Maternal Opioid Misuse (MOM) model in January 2020. The MOM model addresses fragmentation in the care of pregnant and postpartum Medicaid beneficiaries with OUD through a statewide approach involving collaborative work with its nine managed care organizations (MCOs), improved data infrastructure and strengthened provider capacity in underserved areas of the state. This multi-prong approach aims to improve maternal and infant health outcomes through a number of targeted initiatives. MOM model efforts focus on increasing utilization of ambulatory and behavioral health care, such as medication for opioid use disorder, through enhanced MCO case management; improving provider capacity, especially in rural areas, to treat pregnant and postpartum participants with OUD; and ensuring families have access to the community resources that they need by leveraging enhanced care coordination and health information technology infrastructure.

While the focus of the intervention is on the parent, the MOM intake process incorporates a variety of screenings. The health-related social needs assessment includes questions related to safety. While there is no ACEs-specific screening conducted, a variety of questions asked do relate to them, predominantly regarding abuse. Additionally, one pillar of the MOM model, linkages to community and support services, may also prevent some ACEs for participants' children. These services can provide support for issues, including intimate partner violence, and food or housing insecurity. The model does directly address parental SUD. In sum, the MOM model centers upon the prevention of ACEs in working with the parent and their families/companions.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program

The federally required EPSDT benefit provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. The comprehensive benefit aims to ensure that children receive critical screening, preventative services, and treatment services to prevent future medical issues. Program components include preventative, dental, mental health, and developmental services, as well as other specialty services. In Maryland, the preventive care component of the EPSDT Program is known as the Healthy Kids Program. The preventive health care services allow for early identification and treatment of health problems before they become medically complex and costly to treat.

Standards for the Healthy Kids Program are developed through collaboration with key stakeholders such as the MDH Family Health Administration, the Maryland Chapter of the American Academy of Pediatrics, the

University of Maryland Dental School, and the Maryland Department of the Environment. The Maryland Healthy Kids Preventive Health Schedule closely correlates to the American Academy of Pediatrics' periodicity schedule.

The Healthy Kids provider manual and Maryland's EPSDT webpage includes additional information and resources related to the program.

Medicaid Funding for ACEs Screening

The Maryland Medicaid program does not currently reimburse providers for ACEs screenings. To implement coverage for this benefit for both children and adults, a budget initiative would be required. In addition Maryland Medicaid would need to amend its State Plan and regulations, as well as incorporate the benefit into the HealthChoice managed care organization rate setting process. System changes would also be required to allow accredited/credentialed providers to bill Medicaid for the ACEs screening.

Appendix 2: The Maryland Way: Trauma-Informed, Resilience-Oriented, Equitable Care and Culture

The Maryland Way:
Trauma-Informed, Resilience-Oriented, Equitable Care and Culture (TIROE)

The Commissioners on Maryland's Commission on Trauma-Informed Care adopt the following Principles, Definitions, and Implementation Domains to guide our work and recommendations.

Framework:
We define a Trauma-Informed, Resilience-Oriented, Equitable Care and Culture (TIROE)to be composed of this framework:

Trauma-Informed: The 4Rs: A Trauma-Informed Organization/ Culture

- Realizes the widespread impact of trauma and understands potential paths for recovery
- Recognizes the signs and symptoms of trauma in individual, family, organizational, and systemic levels
- Responds by fully integrating knowledge about trauma, and its effects into policies, procedures, and practices
- Resist re-traumatization and create a healing environment for everyone.

Resilience Oriented: The 4Is: A Resilience-Oriented Organization/Culture

- Identifies programs and best practices proven to build resiliency at individual, family, organizational, and systemic levels
- Inoculates the system culture from the effects of stress and trauma proactively rather than reactively by having a strategic plan
- Instills a shared vocabulary and skills for resiliency into every aspect of life of the system.
- Improves the health of the entire system by promoting restoration, health and growth in ongoing ways.

Equitable: The 4Cs: In An Equitable Organization/Culture

- Cultural Humility is actively practiced and modeled throughout all relationships
- Cultural Safety is established and maintained throughout the organization and within its partnerships
- CLAS Standards are fully incorporated into policies, procedures, and practices in a meaningful and identifiable manner
- Community is recognized and engaged for its inherent healing practices and honored for the uniqueness and diversity of its members.

TIROE Principles *(adapted from SAMHSA)*[10]:

- **Safety (Cultural, Physical, Psychological, Social and Moral)** *(Bloom, 2013)*
- **Trustworthiness and Transparency**
- **Inclusion of the Voice of Lived Experience (including Peer Support and Mutual Self Help)**
- **Collaboration and Mutuality**
- **Empowerment, Voice, and Choice**
- **Cultural, Historical and Gender Concerns**
- **Anti-Racism**
- **Anti-Bias**
- **Social Justice**

With the following definitions of the principles:

1. **Safety** includes cultural, physical, psychological, social, and moral safety. Throughout the organization, staff and the people they serve, whether children, youth, adults or families, feel culturally, physically, psychologically, socially, and morally safe; the physical setting is safe and interpersonal interactions promote a sense of safety
    a. **Cultural Safety:** Established principles of practice that include protocols that show respect and ask for permission and informed consent. Through personal knowledge hone critical consciousness of social location and power. Within partnerships engage in relational practices founded in authentic encounters. Throughout the process ensure equity and dignity for all parties. And in developing as Positive Purpose we build on strengths, ensure confidentiality, and do no harm.[11]
    b. **Physical Safety:** All humans are safe from physical harm. The absence of harm or injury that can be experienced by any person from a physical object or practices that include physical objects. Physical objects can include a person, the room itself, furniture, medical equipment, prohibited items, toys, artwork, etc.[12]
    c. **Psychological Safety:** The ability to be safe within oneself, to rely on one's ability to self-protect and keep oneself out of harm's way.[13]
    d. **Social Safety:** The sense of feeling safe with other people. We recognize that there are so many traumatized people that there will never be enough individual therapists to treat them. We must begin to create naturally occurring healing environments that provide some of the corrective experiences that are vital for recovery.
    e. **Moral Safety:** The never-ending quest for understanding how organizations function in the healing process but attempting to reduce hypocrisy that is present, both explicitly and implicitly. A morally safe environment struggles with the issues of honesty and integrity Moral safety reflects an environment that actively defines and redefines a moral universe of integrity, responsibility, honesty, tolerance, compassion, peace, nonviolence, justice, and an abiding concern for human rights. Being morally safe means having a system of

[10] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA). (2014). *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach*. Retrieved from https://store.samhsa.gov/sites/default/files/d7/priv/sma14-4884.pdf.

[11] *http://www.ecdip.org/culturalsafety/*

[12] *Your experience matters.com/learning/safe-spaces/physical-safety/what-is-physical-safety/*

[13] *(Bloom, S. (2013). Creating Sanctuary: Toward the Evolution of Sane Societies. Routledge.)*

values that are consistent, that guide behavior, and that are founded on a deep respect for each other and all living things. In a morally safe environment, there is no "other," no enemy that is fair game for aggression and violence. No scape goat on which it is acceptable to project one's own denied feelings or the denied feeling of an entire group.[14]

2. **Trustworthiness and Transparency**
    a. Organizational operations and decisions are conducted with transparency with the goal of building and maintaining trust among clients and family members, among staff, and others involved in the organization or culture.
3. **Inclusion of the Voice of Lived Experience, including Peer Support and Mutual Self-Help**
    a. **Inclusion of the voice of lived experience** begins with the understanding of the phrase "Nothing About Us Without Us" which recognizes the importance of working with others not for others. We recognize that organizational cultures and community cultures thrive when those who are impacted by the organization and community are active, engaged, and equal partners with those who are working within the organization and community. This work is maintained and advanced when this principle is central to all organizational decision making and quality assurance practices.
    b. **Peer support and mutual self-help** are key vehicles for establishing safety and hope, building trust, enhancing collaboration, and utilizing their stories and lived experience to promote recovery and healing. These are integral to the organizational and service delivery approach and are understood as a key vehicle to build trust, establishing safety, and empowerment.
4. **Collaboration and Mutuality**
    a. There is true partnering and level of power differences between staff and clients and among organizational staff from direct care staff to administrators. There is recognition that healing happens in relationships and in the meaningful sharing of power and decision-making. The organization recognizes that everyone has a role to play in a TIROE approach.
5. **Empowerment, Voice, and Choice**
    a. Throughout the organization and among the clients served, individuals' strengths and experiences are recognized and built upon. The organization fosters a belief in resilience, in the primacy of person-centered service delivery, and in the ability of individuals, families, organizations and communities to heal and recover from trauma. The organization understands that the experience of trauma may be ubiquitous to the lives of those who run the organization, provide services, and/or who come to the organization for assistance and support. As such, operations, workforce development, and services are organized to foster empowerment for staff and clients alike. Organizations understand the importance of power differentials and ways in which clients, historically, have been diminished in voice, limited in choice, and have been often recipients of coercive treatment. Clients are supported in shared decision-making, choice, and goal setting to determine service plans centered on healing and recovery. Clients are supported in cultivating self-advocacy skills. Staff are facilitators of recovery rather than gatekeepers of help, resource, and care. Staff are empowered to work towards trauma informed

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[14] (https://sandrabloom.com/wp-content/uploads/2017-BLOOM-THE-SANCTUARY-MODEL-THROUGH-THE-LENS-OF-MORAL-SAFETY.pdf)

service engagement through adequate training, responsive management, and supportive organizational frameworks. To promote empowerment, voice, and choice throughout the organization, leaders recognize the importance of developing a parallel agency process that fosters feelings of safety among both staff and the clients they serve.

6. **Cultural, Historical and Gender Considerations**
    a. A TIROE organization or community actively moves past stereotypes and biases that are based on race, ethnicity, sexual orientation, age, disability, religion, gender-identity, geography, etc. It offers gender responsive services and leverages the healing power of traditional cultural connections. The organization or community does this by incorporating policies, protocols, and processes that are responsive to the needs of underserved individuals by recognizing and addressing historical and intergenerational trauma. Finally, the organization or community examines and rectifies institutional practices that have disproportionately harmed individuals from underserved groups.
7. **Anti-Racism**
    a. Active commitment to identifying and eliminating racism within all state institutions
    b. Addressing implicit racial bias in state service delivery
    c. Understanding the institutional and structural issues that uphold systematic racism
    d. Changing racist systems, organizational structures, policies and practices and attitudes at the individual, structural, and institutional levels
    e. Power is redistributed and shared throughout the system
8. **Anti-Bias**
    a. Increased awareness of one's personal biases, both implicit and explicit, and the inherent nature of human biases, as well as their impact on interactions with others and organizational policies and practices that institutionalize bias. Actions are taken to mitigate the impact of biases on individuals, organizations, and systems. Individuals, organizations, and systems respect and value differences in people while challenging stereotyping and discrimination to support an inclusive and safe environment for everyone.
9. **Social Justice**
    a. Promoting the life and dignity of all human persons
    b. Addressing inequities in state service delivery
    c. Advancing policies that support equitable access to goods, resources, and services
    d. Full participation through empowerment, voice, and choice
    e. Equal protection under the law.

In addition to these principles, Maryland's TIC Commission recognizes that we must also address and affect the **Positive and Adverse Childhood Experiences (PACEs)** impacting our citizens. We define ACEs to include the original 10 items from the groundbreaking ACEs Study as well as other ACEs that include: Discrimination, Poverty, Racism, Other Violence, Intergenerational Cultural Trauma, Separation, Adjustments or Other Major Life Changes, Bereavement and Survivorship, and Adult Responsibilities as a Child[15]. We reserve the right to add ACEs as the science advances in this area.

The original 10 ACEs are: Child Physical Abuse; Child Sexual Abuse; Child Emotional Abuse; Physical Neglect; Emotional Neglect; Mentally ill, depressed or suicidal person in the home; family

[15] *(HTTPS://numberstory.org)*

member struggling with drug or alcohol addiction; Witnessing domestic violence against the mother; Loss of a parent to death or abandonment, including abandonment by divorce; Incarceration or any family member. **(***https://www.cdc.gov/violenceprevention/aces/about.html)*

In addition to these Principles, the Commission adopts the following:

10 Implementation Domains

(adapted from SAMHSA's concept of Trauma and Guidance for a Trauma-Informed Approach July 2014)[16].

1. **Governance and Leadership**
2. **Policy**
3. **Physical Environment**
4. **Engagement and Involvement**
5. **Cross Sector Collaboration**
6. **Screening, Assessment, Prevention, and Treatment Services**
7. **Training and Workforce Development**
8. **Progress Monitoring and Quality Assurance**
9. **Financing**
10. **Evaluation**

With the following definitions of the implementation domains:

1) **Governance and Leadership:** The leadership and governance of the organization support and invest in implementing and sustaining a trauma-informed approach; there is an identified point of responsibility within each organization to lead and oversee this work; and there is inclusion of the peer voice. A champion of this approach is often needed to initiate a system change process.

2) **Policy:** There are written policies and protocols establishing a trauma-informed approach as an essential part of the organizational mission. Organizational procedures and cross agency protocols, including working with community-based agencies, reflect trauma-informed principles. This approach must be hard-wired into practices and procedures of the organization, not solely relying on training workshops or a well-intentioned leader.

3) **Physical Environment of the Organization**: The organization ensures that the physical environment promotes a sense of safety and collaboration. Staff working in the organization and individuals and families being served must experience the setting as safe, inviting and not a risk to their physical or psychological safety. The physical setting also supports the collaborative aspect of the trauma informed approach through the openness, transparency, and shared spaces.

4) **Engagement and Involvement of People in Recovery, Trauma Survivors, People Receiving Services, and Family Members Receiving Services:** These groups have significant involvement,

[16] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA). (2014). *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach*. Retrieved from https://store.samhsa.gov/sites/default/files/d7/priv/sma14-4884.pdf.

voice, and meaningful choice at all levels and in all areas of organizational functioning (e.g., program design, implementation, service delivery, quality assurance, cultural competence, access to trauma-informed peer support, workforce development, and evaluation.) This is a key value and aspect of a trauma-informed approach and differentiates it from the usual approaches to services and care.

5) **Cross Sector Collaborations:** Collaboration across sectors built on a shared understanding of trauma and principles of a trauma-informed approach. While a trauma focus may not be the stated mission of various service sectors, understanding how awareness of trauma can help or hinder achievement of an organization's mission is a critical aspect of building collaborations. People with significant trauma histories often present with a complexity of needs, crossing various service sectors. Even if a mental health clinician is trauma-informed, a referral to a trauma-insensitive program could undermine the progress of the individual.

6) **Screening, Assessment, Prevention and Treatment Services:** Practitioners use and are trained in interventions based on the best available empirical evidence and science, are culturally appropriate, and reflect principles of a trauma-informed and resilience-based approaches. Trauma screening and assessment, and prevention are an essential part of the work. Trauma-specific interventions and resilience-based approaches are acceptable, effective, and available for individuals and families seeking services. When trauma-specific services are not available within the organization, there is a trusted, effective referral system in place that facilitates connecting individuals with appropriate trauma treatment.

7) **Training and Workforce Development:** On-going training on trauma and peer-support are essential. The organization's human resource system incorporates trauma-informed principles in hiring, supervision, staff evaluation; procedures are in place to support staff with trauma histories and/or those experiencing significant secondary traumatic stress or vicarious trauma, resulting from exposure to and working with individuals and families with complex trauma.

8) **Progress Monitoring and Quality Assurance:** There is ongoing assessment, tracking, and monitoring of trauma-informed principles and effective use of evidence-based trauma specific screening, assessments, and treatment.

9) **Financing:** Financing structures are designed to support a trauma-informed approach which includes resources for staff training on trauma and resilience, key principles of a trauma-informed approach and resilience; development of appropriate and safe facilities; establishment of peer-support, provision of evidence-supported trauma screening, assessment, treatment, prevention, and recovery supports; and development of trauma-informed cross-agency collaborations.

10) **Evaluation:** Measures and evaluation designs used to evaluate service or program implementation and effectiveness reflect an understanding of trauma, resilience, and appropriate trauma-oriented and resilience-oriented research instruments.