Executive Summary
Strategy Meeting on Trauma-Informed Primary Care for U.S. Women Living with HIV
August 22-23, 2013
Aspen Institute, Washington, D.C.

On August 22nd and 23rd, 2013, Positive Women’s Network-USA and the Women’s HIV Program at the University of California, San Francisco, with generous support from the Firestone Trust, convened a group of national experts at the Aspen Institute in Washington, D.C. to discuss the development and dissemination of a new model of trauma-informed primary care for women living with HIV. The meeting was organized in response to a growing body of evidence recognizing the impact of unaddressed trauma and post-traumatic stress disorder (PTSD) on the health of women living with HIV; our own experiences witnessing the devastating impact of trauma on women living with HIV; the lack of an existing model to address these impacts in the context of primary medical care; and calls from multiple federal agencies to develop such a model. The 24 participants included leading policymakers, advocates, and trauma experts from the government, military, academia, and community organizations. At the meeting, a consensus emerged around key elements of the model and strategies for its implementation, as well as next steps to evaluate its effectiveness and scalability. Participants committed to continue working together to refine and publish the model over the next year.

Responding to Trauma: A Remarkable Opportunity
It is increasingly recognized that trauma – childhood and adult physical, emotional and sexual abuse, neglect, loss, and community violence – is associated with the leading causes of morbidity, mortality, and disability in the United States, especially for vulnerable populations of women. The acclaimed Adverse Childhood Events (ACE) study identified a strong dose-response relationship between childhood traumas and common adult conditions such as cardiovascular disease, chronic lung disease, chronic liver disease, obesity, depression and other forms of mental illness, and substance abuse. Both trauma and resultant PTSD are far more common among HIV-positive women than among women in general. Trauma and PTSD are also associated with increased risk of HIV acquisition and with poor outcomes at each stage of the HIV continuum of care, including disengagement from care, medication non-adherence and medication failure. Recent trauma is also linked with higher rates of death among HIV-positive women.

The increasing awareness of the link between unaddressed trauma and poor health outcomes has led to national calls from the Institute of Medicine and others for a response to trauma and PTSD to be embedded in the primary medical care of women and girls. Just two weeks after the meeting, the President’s Interagency Federal Working Group on the Intersection of HIV/AIDS, Violence against Women and Girls, & Gender-Related Health Disparities released a seminal report. A key recommendation from this report is to “develop, implement, and evaluate models that integrate trauma-informed care into services for women living with HIV.”

The Meeting: Building Consensus
Using formal presentations, small working group activities, and large group discussions, meeting participants reached consensus on a number of important elements of a model of trauma-informed primary care. Participants agreed that HIV programs for women offer an ideal milieu to develop scalable models of trauma-informed primary care because of the high rates and poor outcomes of trauma in this population. In addition, these programs already have multidisciplinary care and a culture of innovation and evaluation. Nonetheless, participants agreed that the model should be adaptable to other populations experiencing high rates of trauma/PTSD.
Other areas of consensus included:

1. Core elements of a model of trauma-informed primary care should include at least three broad categories: a safe and comforting trauma-informed clinical environment; systematized patient screening; and interventions/referrals embedded into primary care to address the impact of trauma and PTSD on health outcomes. Effective implementation of such a model is facilitated by having organizational champions and a clear set of trauma-informed organizational values;

2. Existing models and interventions should inform and facilitate the creation of a holistic model of trauma-informed primary care;

3. The model should include screening and interventions for both intimate partner violence and lifetime abuse. Screening and interventions for lifetime abuse should focus on identifying women with physical and mental health consequences of past abuse (e.g., complex PTSD, depression, substance abuse, chronic pain) rather than on all women who have experienced abuse;

4. While the model has core elements, it must be flexible enough for use in different clinical sites and it must embrace genuine partnerships with community-based organizations to realize its goals;

5. Detailing the model’s core elements, nomenclature, and measures will facilitate multi-site evaluation, dissemination and scaling.

**Next Steps**

Developing and disseminating this model has implications beyond the estimated 300,000 women living with HIV in the U.S.; it can be scaled for use with many others who are survivors of abuse, neglect, loss, and community violence.

Over the next 12-months, we seek to expand our collaborative efforts to:

1. Clarify the elements of a model of trauma-informed primary care;
2. Publish the model in a peer-reviewed journal;
3. Coordinate demonstration projects to evaluate the model of trauma-informed primary care with HIV-positive women;
4. Generate a communications and advocacy strategy to support the broad operationalization of trauma-informed primary care for vulnerable populations of women and girls.

**Contacts**

We invite you to contact us for more information or to join us in this effort:

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