FENWAY HEALTH

EQUITY IN ACTION: UNIVERSAL TRAUMA-INFORMED CARE AS A LIFELINE FOR LGBTQ+ PATIENTS

Advocating for Universal Trauma-Informed Care Through Updated Accreditation & Practice

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Executive Summary & Glossary of Terms

LGBTQ+ and transgender and gender-diverse (TGD) communities experience some of the highest rates of trauma exposure—and some of the deepest harm within healthcare systems. Discrimination, misgendering, and re-traumatization are far too common, pushing people away from the care they need and reinforcing cycles of avoidance and poor health outcomes.

Trauma-informed care (TIC) offers a clear and evidence-based solution—one that centers dignity, autonomy, and healing. But despite its promise, TIC is not yet standard in most clinical environments. Structural barriers like rigid reimbursement models, fragmented training, and lack of accountability systems or guidance through accreditation continue to limit its reach.

This issue brief advocates for a universal, systems-level approach to trauma-informed care—one that's embedded in medical education, integrated into clinical practice, and aligned with an updated understanding of the neurobiological consequences of repetitive trauma. It outlines clear, actionable strategies to support long-term implementation, grounded in equity and guided by the Exploration, Preparation, Implementation, and Sustainment (EPIS) framework.

TIC must become the standard of care—not just an optional tool. To truly be trauma-informed, our systems must intentionally center a patient's lived experience every step of the way.

Glossary of Terms as Defined in Issue Brief

Term	Definition
Adverse Childhood Experiences (ACEs)[1]	**Traumatic events before age 18** (e.g., abuse, neglect, household dysfunction) linked to long-term **mental and physical health risks**.
Complex Trauma[2,3]	**Chronic, repeated trauma**, often starting in childhood, that affects **emotional regulation, memory**, and **physical health**.
Neurobiological Perspective[4–6]	An approach that shows how trauma changes the **brain and nervous system**, especially the **amygdala** (fear) and **hippocampus** (memory/emotion).
Trauma-Informed Care (TIC)[7,8]	A care model that centers **safety, trust, and empowerment**, shifting the lens from "What's wrong?" to "**What happened?**"
Universal TIC	Applying trauma-informed principles to **all patients**, regardless of trauma disclosure, to create **inclusive and affirming care**
Value-Based Care Models[9,10]	Payment structures that are based on **patient outcomes** over service volume, but may **limit time** for patient-centered practices like TIC
Capitation Payment Models[11,12]	Providers are paid a **fixed amount per patient**, which can discourage **longer visits** and reduce time for TIC

The Impact of Trauma on Health Disparities

Though overall exposure to trauma in the United States (US) remains high[1,13], many communities experience disproportionate exposure rates and subsequent adverse health outcomes related to trauma. Despite broadening social support for LGBTQ+ communities in recent years, individuals from these communities are exposed to trauma and adversity at an increased rate compared to their cisgender, straight peers.[14–16] Recent shifts in the political landscape have contributed to increased systemic barriers in accessing appropriate support at the federal level. Policy changes and reductions in federally supported data collection related to disparate health outcomes, HIV treatment, and gender-affirming care may hinder efforts to address the specific needs of LGBTQ+ communities. Transgender individuals face significant impact by policies that limit recognition of their identities and restrict access to affirming healthcare.[17] These broad societal factors significantly impact the experience of LGBTQ+ communities in medical care.

"Transgender and gender-diverse (TGD) individuals are more likely to avoid healthcare settings and forgo necessary medical care due to fear of discrimination and mistreatment."

Transgender and gender-diverse (TGD) individuals are more likely to avoid healthcare settings and forgo necessary medical care due to fear of discrimination and mistreatment. As a result, TGD communities have lower rates of healthcare utilization, further exacerbating health disparities.[18] Reports of avoiding healthcare settings increase for people of color in the LGBTQ+ community[18], underscoring the role that intersectionality plays in individuals' healthcare experiences. Although a dose-response model alone cannot fully predict the long-term impacts of repetitive trauma[19]—particularly given the role of resilience factors such as community and social support—the literature consistently demonstrates a clear association between increased trauma exposure and a heightened risk of adverse health outcomes. [20–22]

The minority-stress and resilience model provides a key perspective on the disparate rates of trauma and associated adverse health outcomes in the LGBTQ+ community[23–25], and adds to our understanding of the increased risk members of these communities face in regards to trauma.[2,26–28] *Figure 1*[29] provides a simplified overview of the model, highlighting the foundational aspects. Acknowledging both the proximal and distal stress factors related to identifying with a gender minority group, the minority stress and resilience model (MSRM) seeks to explain the impact of both societal

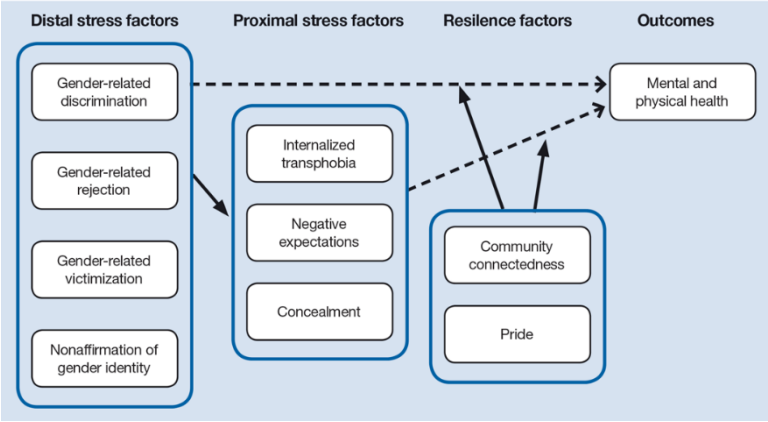

Figure 1: Minority Stress & Resilience Model

experiences and internalized narratives on LGBTQ+ communities.[23,24] Integrating the role of community connectedness, social support, and pride in oneself, the MSRM uses a holistic and comprehensive perspective to understand the disparate impact of trauma on LGBTQ+ and TGD communities.[25]

> *"This brief recommends the universal implementation of trauma-informed care in medical settings to bolster supportive spaces for LGBTQ+ communities"*

Accordingly, this brief recommends the universal implementation of trauma-informed care in medical settings to bolster supportive spaces for LGBTQ+ communities and to mitigate the adverse health outcomes associated with increased exposure to trauma. It seeks to inform policy makers, healthcare leaders, providers, and educators. Aligning with the Substance Abuse and Mental Health Administration's (SAMSHA) six guiding principles (see *Figure 2*[30]) and their practical guide for trauma-informed care (TIC), a universal approach to TIC would equip healthcare organizations with a deeper understanding of how an individual's life experience can shape their experience in clinical spaces.[7,8] Rather than asking, "What is wrong with you?" TIC shifts the focus to "What happened to you?" and acknowledges that effective healthcare must seek to incorporate a holistic understanding of a person's life whenever possible.[8]

Figure 2: SAMSHA 6 Guiding Principles for Trauma-Informed Care

The traditional framework for understanding adverse health outcomes related to trauma in the general population has focused on how a lack of support may lead to adverse health-seeking behaviors, leading to poorer health outcomes. However, the impact of repetitive trauma exposures, or complex trauma[2], has been documented to lead to neurological and physiological differences when compared to individuals without complex trauma.[4,6] This neurobiological perspective on trauma is backed by data gathered from functional MRIs (fMRIs) conducted on individuals with complex trauma. fMRIs are specialized MRI scans used to map out activity in different brain areas, see blood flow between brain structures, and understand the functioning of the brain and its structures.[31] These scans show hyperactivity and hyper development in the amygdala, or in our stress response system (commonly known as the fight-or-flight response), and processes related to fear and anxiety.[5,6] This overactivation is paired with reduced function in the hippocampus—the

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brain region responsible for emotional regulation, learning, and memory.[5,6] These structural changes have a direct impact on the way our nervous system functions on a day-to-day basis.

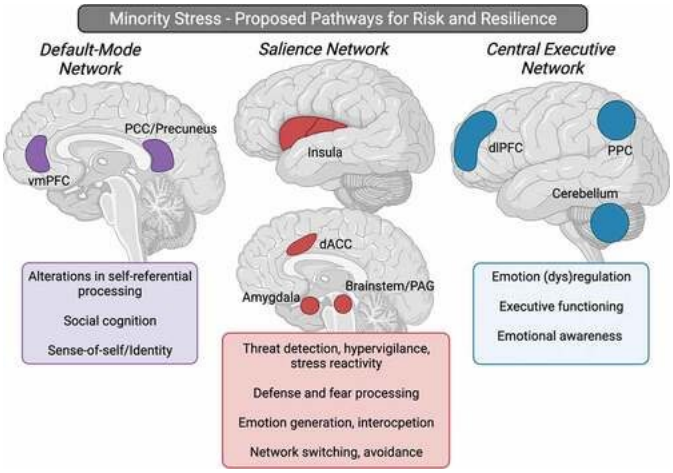

Figure 3: Minority Stress Neural Pathways

When our stress response is activated, our amygdala pumps adrenaline and cortisol into our blood stream to prepare us to respond to an immediate threat. This activation, when prolonged or chronic, has potential to compromise other bodily functions such as immune response, blood pressure, inflammatory response, and heart rate. [5,6] Similar activation has been discussed in studies related to gender minority stress and are depicted in *Figure 3*[32], supporting a framework for understanding adverse health outcomes related to trauma which integrates a neurobiological perspective. [32] While proper support can mitigate some of these structural changes, medical providers need to understand the underlying neurological differences that may be present in patients with trauma to help facilitate better long-term outcomes.

This brief steps away from the traditional individualistic lens and acknowledges this updated understanding of how trauma reflects in the neurobiology and physiology of an individual.[4–6,33–36] Removing the focus on individual health choices, this article advocates an approach to trauma-informed care that employs a socio-ecological lens and recognizes the importance of a holistic approach with all patients. A review of existing literature and conversations with experts in TIC implementation inform the framework for this issue brief.

> *"Since we cannot consistently determine who has experienced trauma, establishing TIC as the standard of care ensures universal implementation and maximizes its impact."*

TIC seeks to equip medical professional, clinicians, and staff of medical organizations with the skills and knowledge necessary to understand the impact of trauma and apply a trauma-informed approach.[8] By empowering trusting relationships, TIC can mitigate adverse health outcomes by increasing patient-clinician collaboration [37,38] and facilitating preventive care and healing. Recent years have produced different approaches to trauma screening as TIC has become more mainstream, but screening practices still display heterogeneity depending on the clinic and provider.[39] Some practices rely on standardized questionnaires such as the Trauma History Questionnaire (THQ), the ACEs questionnaire, or the Pediatric ACEs and Related Life Events Screener (PEARLS) while others rely on provider led screening in the form of clinical interviews.[39,40] Accordingly, since we cannot consistently determine who has experienced trauma, establishing TIC as the standard of care ensures universal implementation and maximizes its impact. TIC can improve the overall quality of

care[37,38,41,42], and the universal implementation of TIC stands to improve healthcare across the country.

An Urgent Need for Trauma-Informed Care

The Centers for Disease Control and Prevention (CDC) estimates that around 64% of adults report at least one adverse childhood experience (ACE), with 1 in 6 reporting four or more ACEs.[1] The more ACEs an individual is exposed to, the higher their risk of developing traumatic stress. Research shows that LGBTQ+ individuals experience ACEs at significantly higher rates than the general population, increasing their risk for long-term health consequences.[16,28] This increased risk extends beyond childhood, with LGBTQ+ communities at much higher risk for experiencing trauma across the lifespan, otherwise known as complex trauma.[15,28] Traumatic stress, such as the stress caused by complex trauma, is the prolonged activation of the body's stress response.[43] Given the disproportionate trauma exposure, combined with the rise in discriminatory rhetoric and policy debates affecting LGBTQ+ communities, there is increasing need for safe and supportive healthcare environments where these people can exist without fear.

TGD individuals need access to safe, gender-affirming healthcare that acknowledges personal history and recognizes the heightened stress that many face within the current sociopolitical context. With such high rates of extensive trauma across the country—particularly among marginalized communities—it is essential for medical providers to understand the impact of traumatic stress on these populations. Research has shown that exposure to traumatic stress during critical developmental periods can affect the development of key brain structures responsible for emotion regulation, stress response, executive functioning, and other essential cognitive processes.[4–6] This prolonged exposure to stress translates to an overproduction of key stress hormones—adrenaline and cortisol—leading to excess stress on an individual's nervous system.[4–6] This excessive stress leaves individuals with complex trauma at much higher risk for developing autoimmune disorders, neurological issues, and chronic pain disorders such as fibromyalgia or endometriosis.[4,20,33–35,44] Some studies even suggest that trauma could be the hidden most common cause of preventable illnesses, with indications that it can be associated with 80% of the leading causes of death in the US.[44]

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Several studies report that medical providers lack formal training in TIC.[41,42,45,46] Although individual institutions offer comprehensive TIC training—such as Harvard and UMass Chan medical schools[47,48]—these pieces of training are typically self-sought and didactic in nature.[41,49–51] Recent studies have indicated that providers prefer

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experiential or mixed-method TIC training to a didactic lecture format.[41,42,46,52] This gives learners the opportunity to practice TIC skills in a simulated environment, allowing them to receive instructor feedback and work through obstacles in real-time. Learner feedback from pilot implementation studies of hands-on TIC training has indicated that this experiential training may be more impactful. Participants in these studies also preferred small group style training where they could discuss case vignettes and engage in critical thinking about skill development.[51–54]

Existing Initiatives & Barriers to Trauma-Informed Care

Systemic Barriers & Initiatives

Considerations for policy makers, healthcare leaders, and educators.

Key Systemic Barriers

A lengthy literature review, key informant interviews, and personal experience in the field reveal that the most significant barriers to TIC within the US medical system exist at the systemic level.[41,55,56] During our discussion, Christopher Menschner, Director of Complex Care Programs at the Center for Health Care Strategies (CHCS) and a leader in TIC implementation, provided key insight into these barriers. Menschner has experience implementing TIC into healthcare organizations and systems across the country. Through his work supporting the implementation of TIC across healthcare systems as a technical assistance provider and funder—including large-scale initiatives like the San Francisco Department of Public Health (SFDPH)[57]—Menschner has gained a distinctive perspective on the systemic hurdles that hinder TIC adoption.

> *"This pressure to maintain cost effectiveness places undue pressure on providers to keep patients within the designated time frame for appointments, meaning less time for providers to build the rapport needed for effective TIC."*

Reimbursement Models and the Impact of Insurance: A fundamental component of TIC is patient engagement and rapport-building, requiring dedicated time with patients[37]. Though there was a shift towards value-based care reimbursement models (VBCM) post-COVID, many health care policy experts and providers still recognize a systemic prioritization of productivity over patient care, despite the shift towards VBCM. [38–40] In theory, VBCM are methods of reimbursement which incentivize positive patient outcomes by tying payment amount to metrics such as quality of care.[9] Often, VBCMs use prospective payments, meaning providers are given a flat payment before providing care.[9,10] This prioritization of productivity leads to increasing time constraints and lack of provider flexibility in clinical practice. These time pressures are particularly harmful for LGBTQ+ and TGD patients, who often require additional time to establish safety and trust due to prior experiences of discrimination or dismissal in clinical spaces.

Medicaid's reliance on managed care organizations (MCOs) further complicates this issue, as capitation-based reimbursement models place financial pressure on providers. In these models, providers receive a fixed per-patient payment, meaning they must absorb financial risk when patient care exceeds the allocated budget.[11,12,59] If providers are effective at reducing costs by keeping care within the fixed rate, capitation provides more financial stability through predictable revenue streams for healthcare organizations.[12] This pressure to maintain cost effectiveness places undue pressure on providers to keep patients within the designated time

frame for appointments, meaning less time for providers to build the rapport needed for effective TIC. With 72 million people on Medicaid as of October 2024[61] and a large percentage of LGBTQ+ individuals enrolled[62], this impact is far-reaching.

Lack of Standardized Training, Universal Guidance, and Accreditation Requirements: A lack of mandatory, standardized TIC training for physicians poses another obstacle. Lack of time has been cited as one of the most significant barriers for providers in practicing TIC.[41,63] Relying on individual providers to seek out their own TIC training in the midst of multiple competing responsibilities is inefficient given already overburdened provider schedules. While core competencies for TIC have been drafted for Undergraduate Medical Education (UME)[64], these competencies are not universally integrated into Graduate Medical Education (GME) curricula, nor are they referenced by the Liaison Committee on Medical Education (LCME) accreditation standards.[65] Providers remain primarily responsible for acquiring TIC training independently without systemic support through accreditation and updated practice standards.

Lack of Funding & Decreased Political Feasibility with Current Administration: At a time of shifting federal priorities, funding for national efforts to advance trauma-informed care (TIC) training may be limited. Recent federal actions have included proposed budget reductions across a range of public health programs, with implications for initiatives related to gender-affirming care and LGBTQ+ health. Indeed, many words pertaining to trauma exposure (e.g., trauma, traumatic, bias, discrimination, exclusion, gender-based violence, hate speech, injustice, oppression, prejudice, racism, segregation, and stereotype) have been flagged by the administration as words to avoid, and numerous federal websites are in the process of removing and/or redlining documents that contain these words.[66] In addition, many institutions, including those that serve LGBTQ+ and other marginalized populations, are facing monumental cuts to their funding, which could significantly affect their ability to provide effective TIC. This rapidly exacerbates existing issues within our healthcare system, where the industrial style of the system and emphasis on revenue has acted as a barrier to providing compassionate models of care for decades.

Systemic Strategies & Initiatives to Facilitate Implementation

Over the last ten years, several providers and health systems have moved toward becoming more trauma-informed organizations engaged in widespread TIC implementation efforts. Many of these efforts use SAMSHA's six guiding principles of TIC to inform their work. Menschner and CHCS have played a supporting role in some of these efforts via a Robert Wood Johnson Foundation funded initiative – *Advancing Trauma-Informed Care*, a multi-site pilot demonstration aimed at identifying and facilitating TIC implementation in the health care sector.
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Center for Health Care Strategies (CHCS) & Other National Initiatives: CHCS has led two national initiatives to implement complex care strategies such as TIC into healthcare organizations and systems.[67] The San Francisco Department of Public Health (SFDPH) implementation project was part of the Advancing Trauma-Informed Care Initiative, which took place from 2015-2019 and involved six pilot sites across the country.[68] The CHCS's later initiative, Advancing Integrated Models (AIM), took place from 2019-2023 and involved eight pilot sites nationwide. Each of the pilot sites selected collaborated with state Medicaid or public health plans and served populations with complex social and healthcare needs. [49] In 2018, the federal government compiled an interagency task force on TIC, resulting in a National Strategy for TIC Operating Plan that outlined a coordinated strategy to build federal capacity for TIC.[69]

However, the task force was only scheduled to convene until 2023 and no efforts were made to sustain the task force beyond that time.[69]

Integration of TIC into Accreditation and Practice Standards: One strategy to bolster the universal implementation of TIC is to integrate TIC into accreditation standards and incentivize updating existing practice standards to align with TIC principles. Removing the burden on individual providers, incorporating longitudinal TIC training across the medical education trajectory by embedding it into curricula at undergraduate graduate, and continuing medical education levels and including it in licensing and accreditation requirements would establish TIC as the standard of care rather than an optional practice. This would move the healthcare system closer to being a trauma-informed system, bolstering the positive impact TIC can have on LGBTQ+ communities, for whom TIC can mean the difference between avoidance or engagement in care.

"A lack of understanding of the long-term fiscal advantages of TIC contributes to administrative pushback."

Institutional/Organizational Barriers & Initiatives

Considerations for Healthcare Leaders, Educators, and Providers.

Barriers to TIC also exist at the institutional level, where a lack of understanding of the long-term fiscal advantages of TIC contributes to administrative pushback. Established workflows, clinic protocols, and clerical responsibilities may have an impact on the success of TIC at a particular institution if they inhibit providers from engaging in training. The importance of staff buy-in at every level of an organization has been emphasized in the research literature on TIC.[37,41,56,70,71]

Key Institutional Barriers

Pushback Over Fiscal Concerns: Menschner notes that pushback often originates from organizational leadership. The upfront cost of implementing TIC drives resistance, with many organizations expressing reservations due to the perceived loss of revenue from dedicated staff training time. Since many providers are required to see a certain number of patients a day to maintain revenue, training providers means less patient visits, thereby lowering revenue streams. To combat this, Menschner emphasizes the long-term savings associated with effective TIC. Since TIC has been shown to increase engagement in primary and preventive care[7,8,38,55,56], costs associated with chronic conditions and unnecessary or emergent medical procedures should ultimately decrease, resulting in long-term savings.

Protected Staff Time for Comprehensive Training: A key lesson Menschner recalls from his experience is the importance of organizations providing protected time for staff to access training. Before SFDPH began its implementation, 45,000 hours of staff training were allocated to ensure all staff could attend the foundational training.[70] Though the method of allocating time for training may differ in a provider setting as opposed to a public agency, this provision of protected time for staff to engage in training underscored the importance of healthcare systems prioritizing training time, rather than expecting staff to access training while simultaneously attending to their other professional responsibilities. [70]

Institutional Strategies & Initiatives

Leadership Buy-in and Organizational Culture Shifts: Ken Epstein highlights the importance taking a systemic approach to implementation. Gaining administrative and leadership support for implementation is integral, stating that "organizational culture shifts must occur before clinical changes can be successful." Cultural change initiatives must be aligned with TIC and embedded in the strategic plan for the organization, including policies and practices aimed at incorporating compassionate and relational care. Staff buy-in across the organization is essential, and both Epstein and Menschner emphasized how important it is to involve clinical and non-clinical staff in training, as well as how vital engaging staff in the implementation process is to ensure long-term sustainability. One notable example of this from SFDPH was the use of "Staff Champions"—members from each agency involved in the transition who were chosen to guide the implementation process in their respective agencies. Champions were selected from all levels and parts of the organization, are supported throughout the process, and have direct access to leadership. These champions formed the Champions Learning Community (CLC), which meets regularly to strategize best practices for aligning SFDPH with trauma-informed principles. [70],[70]

Institutions Providing Training: Several medical schools and healthcare organizations provide comprehensive TIC training for medical students, trainees, and practicing clinicians. For example, Harvard Medical School, UMass Chan Medical School, and Children's Hospital of Philadelphia Center for Violence Prevention all advertise voluntary TIC training programs for medical provider.[30,31,53] In addition, several online modules[51,54] exist that providers can access, as well as a plethora of journal articles and research[1] related to the topic (see Appendix D for expanded list of resources). The National Child Traumatic Stress Network (NCTSN) offers online training modules, as does the University of Buffalo. [73,74]

[1] TIC Implementation Resource Center - CHCS

Individual Barriers & Opportunities

Consideration for Providers & Educators.

Key Barriers for Providers & Individuals

Low Confidence Resulting from Lack of Training: Medical providers often cite a lack of confidence in engaging in TIC, which has been associated with the lack of training they receive on the subject.[41,42,45,52,70] Without comprehensive, tailored training integrated throughout the field of medicine, providers may not feel prepared to engage in effective TIC.[41,45,52] This is particularly true in specialty areas such as gynecology, where the invasive and sensitive nature of exams runs a high risk of re-traumatization or distress for patients, in particular patients in the LGBTQ+ community.[75,76]

Provider Trauma, Secondary Trauma, & Burnout: The COVID-19 pandemic highlighted a crisis amongst healthcare providers, with some national studies suggesting that over 50% of clinicians experience symptoms of burnout.[77] Medicine has long been regarded as a field that poses a significant strain on an individual's mental health due to long working hours, high levels of stress, and repeated exposure to vicarious trauma. Research has shown that physicians and medical providers experience burnout at a much higher rate than the general population,[77,78] and LGBTQ+ or TGD providers face even higher rates of burnout.[16] A similar issue presents in medical education programs, where LGBTQ+ students report lower levels of satisfaction in their programs, lower retention, and higher levels of stress or burnout.[79,80] Systematic reviews and evaluations of previous TIC implementation efforts in healthcare spaces have indicated that organizational implementation decreases staff turnover and improves overall staff wellbeing, decreasing burnout. [56]

Opportunities for Providers

Individual Trainings for Providers are Widely Available: As stated, several institutions offer training for TIC that providers can seek out on their own time to improve their practice. Individual providers may engage in online modules, read research articles, or access any TIC materials available on the web. A resource list is provided in Appendix C.

Cross-Sector Collaboration & Collaborative Care Teams Increase Facilitation: Though the current design of the healthcare system leaves providers with limited time to build rapport with patients, increased utilization and reliance on cross-sector collaboration or collaborative care teams can support providers in practicing TIC within the limits of the current system.[37,81]

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Proposed Solutions

To further facilitate the universal adoption of TIC, existing practice standards should be updated to align with recognized TIC guidelines and proposed competencies. **UPDATED CLINICAL PRACTICE STANDARDS** should integrate techniques that empower patients to use their voice and exercise control over

their healthcare, such as self-swabbing for STIs or obtaining similar samples independently, particularly for transgender and gender-diverse (TGD) patients who may experience traditional exams as retraumatizing. Self-swabbing techniques have been verified as a viable alternative to provider-obtained samples and have been studied explicitly in use with TGD patients, providing an excellent example of trauma-informed clinical interventions that center the dignity and autonomy of LGBTQ+ and TGD patients.

Though a system-wide shift toward value-based care payment models that emphasize patient interaction time and greater provider flexibility would be the most significant facilitator of TIC uptake, **INTEGRATING TIC THROUGHOUT THE MEDICAL EDUCATION TRAJECTORY** is a key strategy to increase its adoption in clinical practice nationwide. While TIC competencies exist for UME[64], they are not yet universally integrated or included in LCME accreditation standards. [47] Furthermore, no formal TIC competencies have yet been created for GME or CME training.

Update and Expand TIC Competencies

To address the lack of standardized clinician training and promote the widespread adoption of TIC, we advocate:

- **Expanding TIC competencies** to encompass Graduate Medical Education (GME), Continuing Medical Education (CME), and residency and fellowship training.
- These core competencies should be updated to:
    - Reflect the ***neurobiological perspective*** discussed earlier in this brief.
    - Include ***experiential learning opportunities,*** allowing learners to practice and receive feedback on their TIC skills.
    - Emphasize the importance of engaging in ***universal TIC*** to bolster support for patients with or without histories of trauma — particularly LGBTQ+ and TGD individuals, who face elevated risk for healthcare-related harm.

Integration of Competences into Medical Education Curriculum

The promulgation of these competencies and the resulting curricula must be accompanied by tools that evaluate:

- ***Learner outcomes*** (e.g., performance on TIC-related NBME and Board exam questions)
- ***Patient outcomes*** (e.g., engagement in care, clinical benchmarks met).

> *"Integrating TIC throughout the medical education trajectory is a key strategy to increase its adoption in clinical practice nationwide."*

These evaluation measures are critical to ensure ***continuous quality improvement*** and long-term success.

These proposed solutions can provide increased systemic support for providers to engage in universal TIC. As illustrated in the **logic model** (*Appendix A*), the universal adoption of TIC as the standard of care has the potential to facilitate improved patient care and ultimately enhance health outcomes nationwide.[38] To promote the implementation of these solutions, a preliminary

implementation plan is provided which utilizes an evidence-based public health framework for implementation – Exploration, Preparation, Implementation, and Sustainment (EPIS).[82]

Implementation Overview Using the EPIS Framework

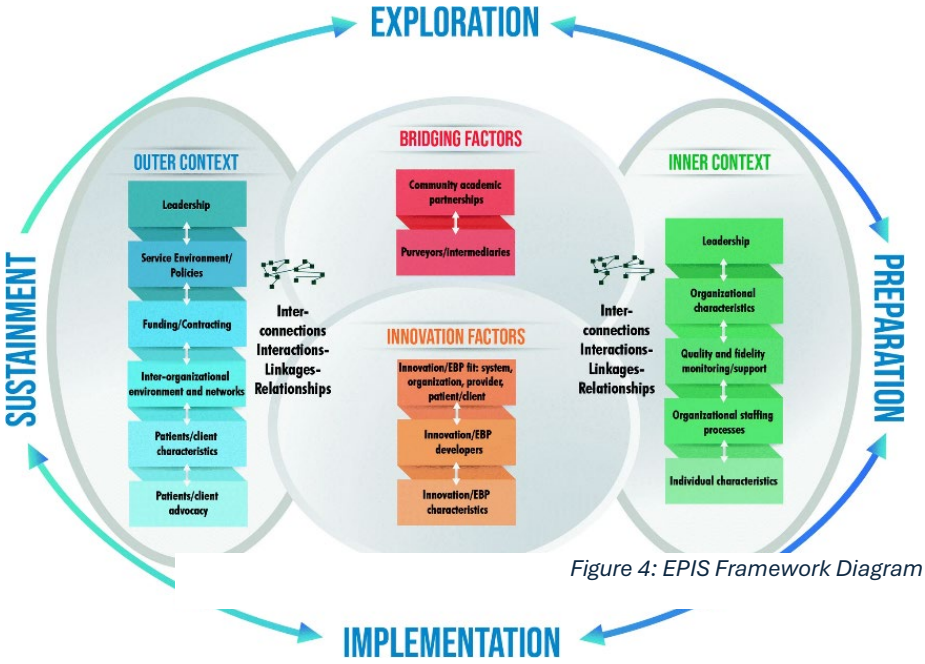

Figure 4: EPIS Framework Diagram

To ensure updated competencies and aligning curriculum can be effectively developed, piloted, and sustained, this implementation plan has been structured using the Exploration, Preparation, Implementation, and Sustainment (EPIS) framework[82], which provides a stage-based guide for successful integration and continuous improvement. This highly cited and widely used approach provides practical guidance for program development, stakeholder engagement, pilot testing, and long-term sustainability. Developed to address systemic issues using a community-driven, person-focused approach, the EPIS framework aligns with many of SAMSHAs guiding principles for TIC. EPIS integrates assessment of both the outer and inner contexts of an intervention, the bridging factors between the two, and the innovation factors. The EPIS diagram seen in *Figure 4*[82] provides a concise visual overview of the stages and relational nature of the EPIS framework.

A process map diagram is provided in Appendix B to give a simplified overview of the implementation plan, and a preliminary draft of suggested competencies can be found in Appendix D as a foundation.

EPIS Phase 1: EXPLORATION

Goal: Identify system needs, build foundational knowledge, engage stakeholders
Timeline: 3–6 Months

The exploration phase focuses on conducting comprehensive needs assessment, engaging key stakeholders, and building community relationships to guide implementation. A multi-pronged needs assessment will analyze existing medical education curricula and identify gaps. A survey adapted from the validated CPTS Provider Survey will be disseminated to providers across disciplines. If funding allows in-depth interviews with providers and patient focus groups will be conducted to contextualize the data further.

Key stakeholders, including educators, providers, medical students, community members, and accreditation bodies, will be engaged in collaborative discussions to

shape the approach. Individuals will be identified to support the process through implementation, evaluation, and sustainment through established roles on a Community Advisory Panel (CAP). Using findings from these efforts, the team will identify core gaps and key focus areas to address during program development.

EPIS Factors:

- ***Outer Context Factors:*** Medical education policies, sociopolitical environment, accreditation standards, funding sources
- ***Inner Context Factors:*** Institutional readiness, provider awareness, medical school culture, leadership buy-in
- ***Bridging Factors:*** Community–institution partnerships, CAP formation
- ***Innovation Factors:*** Preliminary trauma-informed competencies and educational strategies, community led development.

Action Items	Responsible Parties

• **CONDUCT A MULTI-PRONGED NEEDS ASSESSMENT**
  • **FACILITATE COMMUNITY-BASED PATIENT FOCUS GROUPS** to identify service gaps perceived by patients/survivors.
  • **(IF FUNDED) CONDUCT IN-DEPTH PROVIDER INTERVIEWS**
	• Training & Implementation Team
	  ▪ Focus groups & Interviews conducted by implementation team

• **ENGAGE KEY STAKEHOLDERS IN STRUCTURED PLANNING SESSIONS** - *Include educators, students, providers, community leaders, and accrediting bodies.*	• Director • Patient Advocates • Research Coordinator • Lead trainers
• **FORM THE COMMUNITY ADVISORY PANEL** - *Ensure diverse representation across community, education, and healthcare sectors*	• Training & Implementation Team • Stakeholders
• **USE ASSESSMENT DATA AND EXPERT INPUT TO IDENTIFY KEY FOCUS AREAS AND CURRICULUM GAPS.**	• Implementation team

EPIS Phase 2: PREPARATION

Goal: Develop competencies, build infrastructure, and prepare for pilot testing
Timeline: 6–12 Months

During the preparation phase, foundational program components will be revised and finalized. Drafted trauma-informed care competencies will be updated in collaboration with the Community Advisory Panel and aligned with UME core competencies. Partnerships with organizations, such as the National

Collaborative on Trauma-Informed Healthcare Education & Research (TICHER), will support the development of inclusive, interdisciplinary TIC standards. A complete set of competencies will be proposed, emphasizing TIC as the standard of care across specialties.

In tandem, an advocacy letter will be submitted to accreditation boards, including a commitment to pilot the proposed curriculum. A curriculum proposal will also be developed, grounded in literature on the impact of TIC on patient outcomes, experience, and staff retention. Curriculum materials will prioritize experiential learning, the neurobiology of trauma, and providers' impact on facilitating positive outcomes for their patients. At this stage, pilot site selection and outreach will begin.

EPIS Factors:

- ***Outer Context Factors:*** Align with national education standards (e.g., AAMC, TICHER), funding, sociopolitical environment, scattered ongoing TIC efforts.
- ***Inner Context Factors:*** Institutional collaboration and resource development, faculty comprehension, leadership buy-in.
- ***Bridging Factors:*** Formal partnerships and shared leadership through the Community Advisory Panel (CAP).
- ***Innovation Factors:*** Development and refinement of TIC competencies and curriculum, broad scale collaboration to prep for scaling.

Action Items	Responsible Parties
• **Revise drafted competencies based on Phase 1 findings -** *Collaboratively refined through CAP workshops*	• CAP • Implementation Team • Training Team
• **Align revised competencies with national standards, using TICHER and other expert guidance -** *Ensure cross-discipline relevance and accreditation compatibility*	• Director - *responsible for ensuring cross-sector collaboration* • Community Advisory Panel (CAP) • Implementation Team • Training Team
• **Draft comprehensive TIC competency set -** *Emphasize universal applicability regardless of trauma history, understanding of neurobiological consequences, and patient lived experience.*	• CAP • Implementation Team • Training Team
• **Submit an advocacy letter to medical accreditation bodies -** *Call for formal inclusion of TIC in UME and GME standards*	• Director • CAP sign in support.

• **DEVELOP A FULL TIC CURRICULUM PROPOSAL** - *Include literature review, supporting data, and implementation rationale*	• Director • CAP • Training Team • Implementation Team
• **DESIGN CURRICULUM AND TRAINING MATERIALS** - *Prioritize experiential learning, learner and patient outcomes analysis, trauma neurobiology, and the provider's impact on positive outcomes.*	• Director • CAP • Training Team • Implementation Team
• **IDENTIFY AND INITIATE PARTNERSHIP DISCUSSIONS WITH PILOT SITES** - *Ensure institutional readiness and alignment.*	• Director • Research Coordinator • Lead Trainer

EPIS Phase 3: IMPLEMENTATION

Goal: Launch and evaluate the curriculum at pilot site(s)
Timeline: 12–24 Months

This phase focuses on delivering the curriculum in the real world. Partnerships with selected medical schools will be formalized. Faculty, staff, and students from each site will participate in the CAP to ensure contextual responsiveness.

Faculty and staff will be trained in TIC principles and practices. Curriculum delivery will begin at the start of a semester with an incoming cohort, with pre-tests and post-tests administered to assess changes in student knowledge. Longitudinal data collection will track outcomes over time, while school-wide surveys and focus groups will capture student, faculty, and staff feedback. A final report summarizing pilot outcomes will be prepared for publication and submitted to accreditation bodies.

EPIS Factors:

- ***Outer Context Factors:*** Leverage national momentum for TIC integration, sustainable finding sources, sociopolitical environment,
- ***Inner Context Factors:*** Train and support institutional faculty and staff
- ***Bridging Factors:*** Pilot site leaders on Implementation Board; bidirectional feedback
- ***Innovation Factors:*** Deliver and assess trauma-informed curriculum

Action Items	Responsible Parties
• **FORMALIZE PILOT SITE PARTNERSHIPS AND INTEGRATE THEM INTO THE CAP** - *Include students, faculty, and administrators from pilot institutions*	• Director • Community Advisory Panel (CAP) • Pilot site faculty/staff & leadership

• **Deliver faculty/staff training on trauma-informed principles and pedagogy** - *Support modeling and sustainability of TIC instruction*	• Training team • Pilot site faculty/staff & leadership
• **Pilot the curriculum with a full academic cohort** - *Administer pre-/post-tests to assess learning outcomes*	• Training team • Pilot site leadership • Pilot site faculty
• **Conduct long-term follow-up evaluation with the pilot cohort** - *Evaluate changes from matriculation to graduation*	• Implementation Team • Pilot site leadership • CAP
• **Facilitate student focus groups and school-wide surveys for curriculum feedback** - *Supplement with faculty/staff meetings for additional input*	• Implementation Team
• **Analyze pilot outcomes and prepare a comprehensive report** - *Submit to accreditation boards and academic journals*	• Implementation Team • Pilot site faculty & leadership • CAP

EPIS Phase 4: SUSTAINMENT

Goal: National rollout, institutional integration, and continuous quality improvement
Timeline: 24–36 Months and Ongoing

In the sustainment phase, the curriculum will be expanded nationally with the support of accreditation bodies. The program will be supplemented with professional development, consultation services, and support groups for ongoing implementation across institutions.

Continuous evaluation and quality improvement processes will be embedded. Regular curriculum reviews, performance metrics, provider feedback, and patient experience surveys will inform iterative updates. These efforts will ensure that trauma-informed education remains aligned with evolving best practices and responsive to community and institutional needs.

EPIS Factors:

- ***Outer Context Factors:*** Engage national accrediting bodies, policymakers, and funders
- ***Inner Context Factors:*** Build institutional capacity and infrastructure for ongoing TIC education
- ***Bridging Factors:*** Create national networks for mentorship, training, and evaluation

- ***Innovation Factors:*** Adapt curriculum based on real-world feedback and emerging best practices

Action Items	Responsible Parties
• **Expand implementation across medical schools nationally -** *Prioritize schools that express readiness and have aligned values.*	• Implementation Team • Director • Community Advisory Panel (CAP)
• **Provide professional development for faculty and administrators -** *Include online trainings, communities of practice, and office hours*	• Training team
• **Offer ongoing consultation and technical assistance to partner institutions -** *Support rollout, troubleshooting, and sustainability planning*	• Implementation Team • Training Team
• **Launch a national monitoring and quality improvement program -** *Develop metrics to evaluate fidelity, outcomes, and satisfaction*	• Implementation Team • CAP
• **Conduct regular reviews of TIC curriculum impact -** *Use patient experience surveys, provider feedback, and academic outcomes*	• Implementation Team • CAP
• **Iteratively revise and improve curriculum based on new research and feedback -** *Maintain relevance and rigor as trauma science evolves*	• Implementation Team • CAP • Institutions

Conclusion

In consideration of the disproportionate impact of trauma on LGBTQ+ communities, the overall prevalence of trauma, and the inconsistent application of trauma-informed care (TIC) standards in healthcare, this brief advocates for the integration of TIC-aligned competency standards into graduate medical education (GME) curricula. By emphasizing neurobiological foundations and experiential learning, updated curricula can equip providers with the tools to create safer, more supportive clinical environments. This shift empowers providers to play an active role in identifying, preventing, and treating trauma, while improving the quality of care across diverse patient populations. As new barriers to affirming and accessible care continue to emerge for transgender and gender diverse (TGD) individuals, TIC offers a timely opportunity for providers to meaningfully impact patient lives when community support is most needed. In alignment with the minority stress resilience model, TIC strengthens protective factors and increases community support, serving as a vital intervention against trauma-related disparities. If you are an LCME accredited GME program or affiliate hospital and are interested in partnering on this implementation plan, please reach out to the author –

"This brief advocates for the integration of TIC-aligned competency standards into graduate medical education (GME) curricula."

Martine Geary-Souza, MPH, BSW	mgsouza@bu.edu

"TIC strengthens protective factors and increases community support, serving as a vital intervention against trauma-related disparities."

"As new barriers to affirming and accessible care continue to emerge for transgender and gender diverse (TGD) individuals, TIC offers a timely opportunity for providers to meaningfully impact patient lives when community support is most needed."

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I could not have undertaken this journey without my parents. Thank you for believing in me, for giving me every opportunity to succeed, and for always pushing me to be better than I think I can be. Thank you for raising me with the grit and determination necessary to overcome all that life has thrown at me.

For my fellow survivors—this is for you.

May we continue to build brave, supportive spaces for collective healing.

Spring 2025

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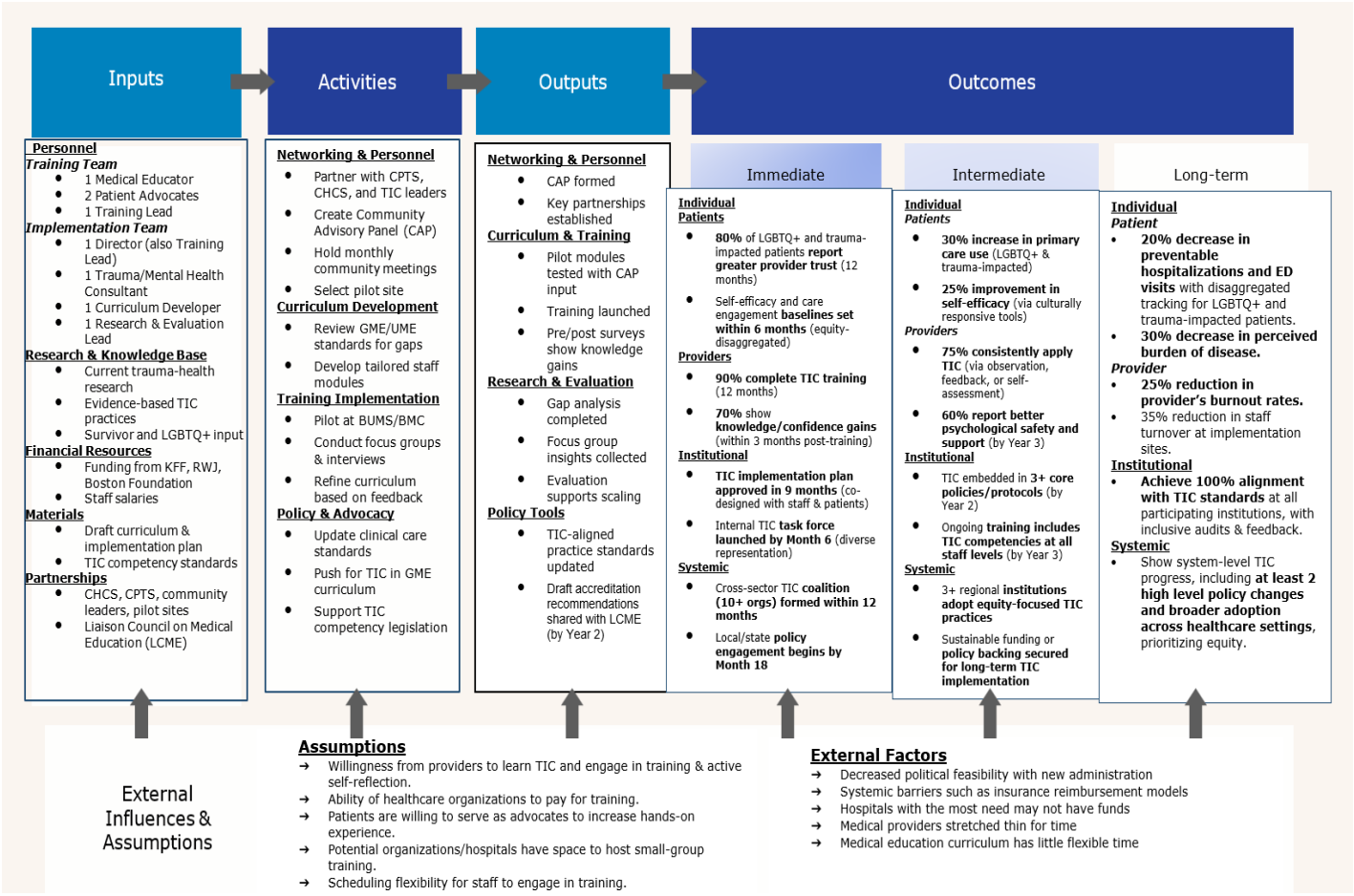
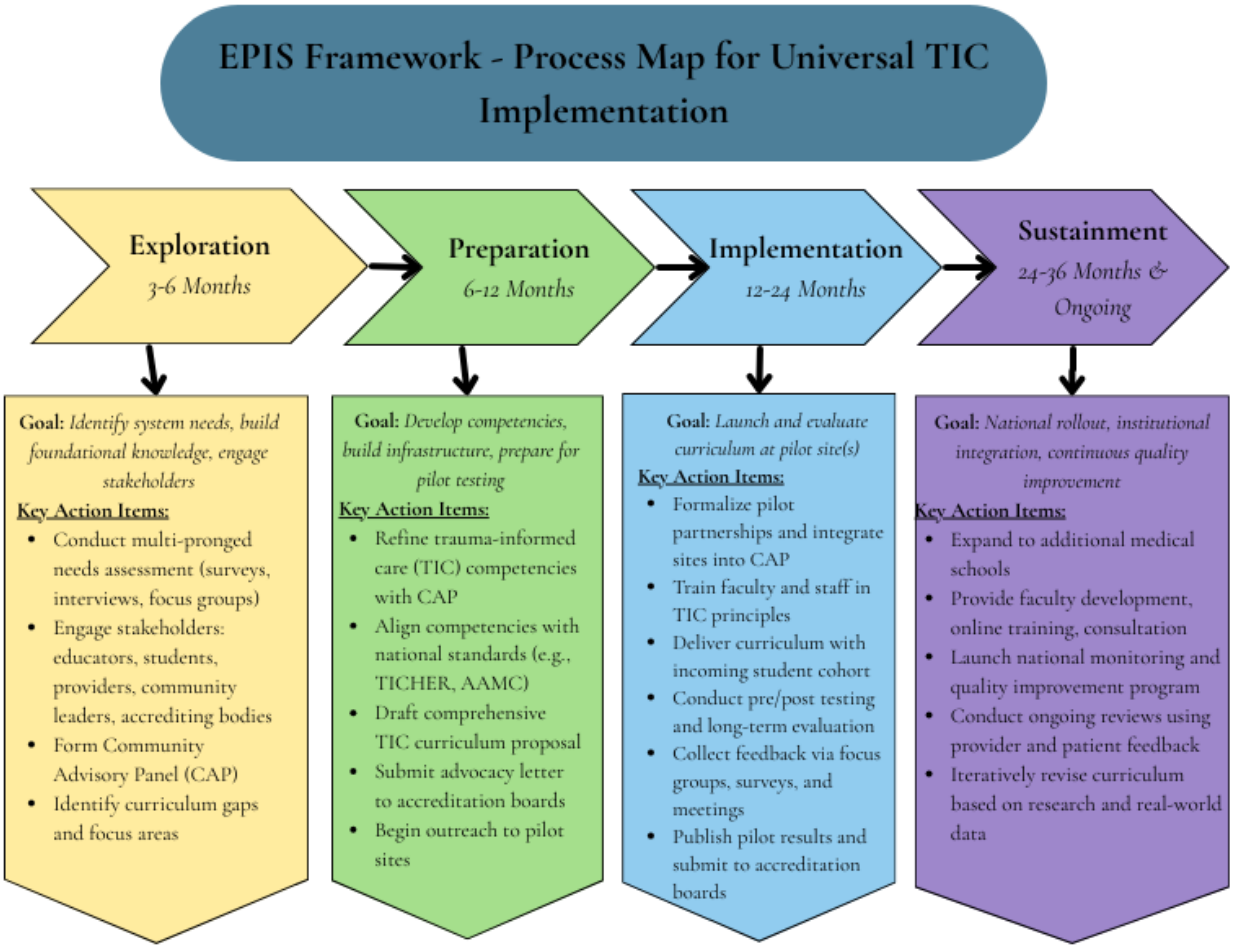
Appendix A: Logic Model



Appendix B: Process Map



Appendix C: Resource List for TIC

- Harvard Medical School Online Training Module
- UMass Chan Medical School TIC Training – offers both online and in-person training on variety of TIC topics.
- Children's Hospital of Philadelphia – Center for Violence Prevention TIC Training
- Center for Health Care Strategies TIC Implementation Resource Center
- MA Childhood Trauma Task Force Sector Specific TIC Resource List
- National Child Traumatic Stress Network TIC Page
- The Center for Pediatric Traumatic Stress Healthcare Toolbox

Appendix D: Suggested Updates for TIC Competencies

To support the universal implementation of trauma-informed care (TIC) in clinical settings, particularly for LGBTQ+ and TGD populations, the following **CORE COMPETENCY DOMAINS** are proposed for integration into Graduate Medical Education (GME), Continuing Medical Education (CME), and residency/fellowship training. These reflect both the neurobiological foundations of trauma and the need for experiential, equity-centered learning.

This list serves as a ***foundational framework*** to guide curriculum development and institutional adoption.

1. Foundational Knowledge of Trauma

- Understand definitions and types of trauma, including complex trauma and historical/intergenerational trauma.
- Recognize the prevalence and disproportionate impact of trauma on LGBTQ+ and TGD populations.
- Explain the Minority Stress & Resilience Model and its implications for care.

2. Neurobiological Impact of Trauma

- Describe how trauma alters brain structure and function (e.g., amygdala, hippocampus).
- Understand the physiological consequences of chronic stress (e.g., cortisol, inflammation).
- Integrate this knowledge into diagnostic and treatment planning.

3. Patient-Centered Communication & Trust Building

- Demonstrate skills that prioritize safety, agency, and collaboration in clinical interactions.
- Use nonjudgmental, affirming language—especially with LGBTQ+ and TGD patients.
- Incorporate shared decision-making and informed consent practices that honor autonomy.

4. Equity & Intersectionality in TIC

- Recognize how structural oppression and discrimination contribute to trauma, and the role the medical system has played in causing trauma.
- Identify ways intersectional identities affect trauma responses and care experiences.
- Commit to antiracist, anti-oppressive, and inclusive approaches.

5. Trauma-Informed Clinical Practices

- Apply trauma-informed strategies in exams and procedures (e.g., patient-led self-swabbing, use of chaperones, explaining before touching).
- Modify care environments to reduce triggering stimuli and enhance emotional safety.

- Adapt practices to minimize risk of re-traumatization in high-risk specialties (e.g., gynecology, emergency medicine).

6. Self-Reflection, Bias Awareness, and Vicarious Trauma

- Engage in self-assessment to identify implicit bias and assumptions about trauma.
- Practice strategies to prevent burnout and manage vicarious trauma.
- Build reflective habits that support ongoing professional development and accountability.

7. Systems-Level Advocacy & Implementation

- Understand the role of TIC in healthcare quality, retention, and equity.
- Advocate for systems change (e.g., protected time for TIC training, reimbursement models that support longer patient visits).
- Collaborate with interprofessional teams and community stakeholders to advance TIC practices.

🔹 *Note: These domains are aligned with existing UME TIC competency work and are intended to be further developed in collaboration with educators, accreditation bodies, and LGBTQ+ community stakeholders.*