RESILIENT BEGINNINGS COLLABORATIVE
November 1, 2018
Session #2
Our Program Team

Veenu Aulakh, Program Director
Megan O’Brien, Program Manager
Angela Liu, Program Coordinator
Today's Agenda

- Welcome & Overview
- Creating & Sustaining Trauma and Resilience Informed Work Environments
- Key Perspectives, Strategies, & Tools for Assessing & Identifying Trauma & Resilience
- Assessing & Identifying Trauma & Resilience: Break Out Groups
- Evaluation Updates: Sharing & Discussing Results from the Baseline Assessment
- Team Time
- Looking Forward: Early Partnership Success Stories
Team Sharing

Trauma-Informed Care Training
- Petaluma Health Center
- LifeLong Medical Care
- Ravenswood Family Health Center

Identifying & Assessing for Trauma and Resilience
- Marin Community Clinics
- UCSF Benioff Children’s Hospital
- San Mateo Medical Center

Partnership Work
- West County Health Centers
Today’s Agenda

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- Creating & Sustaining Trauma and Resilience Informed Work Environments
- Key Perspectives, Strategies, & Tools for Assessing & Identifying Trauma & Resilience
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- Evaluation Updates: Sharing & Discussing Results from the Baseline Assessment
- Team Time
- Looking Forward: Early Partnership Success Stories
Potential Topic Areas

1. What comes next after a positive screen?
2. Getting buy-in from frontline staff and providers
3. Working to engage families in the assessment process
4. ???
5. ???
6. ???
Housekeeping

Bathroom

WiFi

Take Breaks!
Special Welcome!
Building On Resilience
“The ability to use adversity to its advantage allows bristlecones to evolve into living monuments of time.”
Resilience & Adversity Activity

1. Reflect on a difficult or challenging time in your life. It could be big or small. You won’t be asked to share the specific example you are reflecting on.

2. Consider: *Out of what time, what adaptive strategies have you incorporated into your life that have benefitted you?*

3. Jot down your thoughts on a post-it note.
Resilience & Adversity Activity

1. Find someone you don’t know well. Introduce yourself. Share your adaptive strategies.

2. Remember you don’t have to share the difficult/challenging time you were thinking of if you don’t want to.

3. Thank the person who shared with you.

4. Find one more person & repeat the process.
Reminder

While we are talking about trauma, we are also talking about resilience.
Phases

**Phase 1: Deepen Trauma-Informed Organizational Practices**
- Identify project team
- Identify TA needs
- Work with evaluator to define metrics
- Participate in organization-wide TIC training

**Phase 2: Test and Implement Care Delivery Changes**
- Develop action plan
- Identify community partners
- Co-design strategies with partners, patients, and families

**Phase 3: Sustain and Spread**
- Document workflows and protocols
- Reinforce and sustain partnerships
- Build referrals
- Spread lessons learned
Phase 2: Test & Implement Care Delivery Changes

- **Develop a plan** to identify the activities and approaches for implementation and how CCI technical assistance resources would support success.

- **Begin testing and implementing** the core elements.

- Identify **community partners** with expertise in early childhood interventions and aligned with goals of addressing trauma.

- **Co-design strategies** with community partners and patient advisory groups to ensure referral resources and coordination efforts meet needs.
Where We’re At

- We are early. There isn’t a roadmap or recipe book for doing this work.

- BUT there’s a lot we can learn from others, including folks in this room.

- We know that there are a set of core ingredients to doing this work. But they need to be adapted to fit your environment.
Key Resources

**SAMSHA Toolkit**
https://store.samhsa.gov/shin/content//SMA14-4816/SMA14-4816.pdf

**PICC Framework**
https://picc.jhu.edu/the-toolkit.html

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**Oe**
Office Environment
1. Develop and Foster a Trauma and Resilience-Informed Environment

**Cr**
Community Relationships
2. Build Relationships with Communities to Support Families

**Fe**
Family Engagement
3. Engage with Families in Their Own Care

**As**
Assess Health
4. Assess Whole Family Health and Resilience

**Ad**
Address Health
5. Address Whole Family Health and Resilience

**Co**
Coordinate
6. Coordinate Services and Supports for Families
Key Resources

CHCS: Lessons from their national collaborative
https://www.chcs.org/topics/trauma-informed-care/

CHCS: Key Ingredients for TIC
https://www.careinnovations.org/rbc-portal/
Site Visits

1-2 visits to exemplar organizations

- Intended to inspire teams and provide guidance for work in the program
- Location pending; 1 will most likely occur in Southern California & the other on the East Coast
- Expect to send up to 2 team members per site visit
- Will occur in first quarter of 2019
PICC Element #1: Creating & Sustaining Trauma and Resilience Informed Work Environments
Office environment

Office Environment

1. Develop and Foster a Trauma and Resilience-Informed Environment
Team Presentations:  
What worked, what didn’t, and what’s next?
What was your training plan and approach?

• 200 employees

• Initial plan was four 2-hour sessions held on two separate days = 50 employees per session

• Sessions occurred on a morning set aside once a month for clinic-wide meetings

• Coordinated closely with our Staff Development Director and Trauma Transformed

• After first round of trainings (2 sessions), we changed the logistics for the remaining 2 sessions.
  • Combined remaining groups into one large 100 person session
  • Allowed for a break time half-way through sessions
  • Provided coffee / snacks
What worked well?

• Staff Development Director was able to quickly schedule sessions and coordinate logistics with Trauma Transformed

• As requested, we separated groups into a diverse mix of employees

• Good attendance

• Some employees voiced appreciation that this topic was considered important enough to be presented to entire clinic
What could have gone better or differently?

• First round of trainings – presenter did not click with employees. New presenter was used for second round of trainings.

• First round of training – too much material for length of session. Improved second round.

• Would have liked more emphasis on organizational trauma and it’s ultimate impact on patient care.

• Key executives did not attend trainings
What advice or tips do you have for teams that haven’t completed the training?

- Need to emphasize the “why” of the training – both at the beginning and the end
- Work closely with Trauma Transformed to reach the message you are hoping to portray
- Allow time for breaks, coffee, nourishment
What are your plans or next steps now that the training is complete?

• Re-train pediatric and behavioral health teams internally
  • Focus on importance of resiliency
  • Focus on organizational trauma and its ultimate impact on patient care
  • Introduce our pilot project
• Work with RBC/TT to create an executive level training that focuses on organizational trauma
Petaluma Health Center

Alaina Cantor
Tiffany Jimenez
Jessicca Moore
Training Plan

- All-staff 3-hour training
- 2 large groups – 250 people & 150 people
- Halloween celebration after
- Logistics & prep-work
  - Flyer to staff with 3 Talking points
  - Invitations, announcements about what & why
A.C.E.
(Adverse Childhood Experiences)
All Staff Training

COSTUMES ENCOURAGED!

- Recognize toxic stress
- Understand the impact of early trauma
- Learn tools to build resilience
- Make PHC a healing place

LOCATION: SALLY TOMATOES
What went well

- Coordination with Presenters
  - Logistics
  - Slides review
  - What we want: Tools, connecting to fires

- All staff trained at the same time
- Videos / vignettes
What could have gone better/differently?

- More bathrooms, stagger breaks
- Orientation for presenters to our services & culture
- Chance for us to review a few evaluations
- Not enough time to elicit additional input from staff
- More role play / practice with tools
Advice for other teams

- Coordinate with Presenters
- Think carefully about logistics – place, agenda, introductions, food, facilities, travel time, seating arrangement (we mixed it up)
- Combine with something fun!
Next Steps

- More practice with skills, Role Play
- Outreach to each department – how can leadership support making this a reality?
- Elicit feedback from staff / reminders about PEARLS in the team room, common work areas
- EAP – find out more info, can we bring some services on site?
- Pair check ins
  - how do you feel (one word)?
  - One success this week?
- ACE Screening – how & timeline
Team Presentations:
What worked, what didn’t, and what’s next?
Dear LifeLong employee,

Over the next several months, we are asking all staff to attend and participate in a Resilient Beginnings 101 training to support our involvement in the Resilient Beginnings Collaborative. You will soon receive announcements from your direct supervisors and/or Angie Adams from LMC HR Department on Health Stream registration logistics.

What is the Resilient Beginnings Collaborative?

Our organization is excited to partner with the Resilient Beginnings Collaborative, which was derived from a partnership with Genentech Charitable Giving and the Center for Care Innovations (CCI). The Resilient Beginnings Collaborative is a learning program dedicated to addressing childhood adversity in pediatric safety net care settings. It has been created in order to strengthen organizational capacity and to prevent and mitigate the effects of trauma in young children and the workforce that interact with these young children.

What is the Resilient Beginnings 101 training?

The 2-hour Resilient Beginnings 101 is a foundational training on how trauma and stress impact individuals and the organizations that we work within, and how we can heal from the impact of trauma and build resilience on individual and organizational levels. This training will be part didactic, part interactive and every participant will walk away with tools and takeaways.

All staff throughout our organization will attend this training over the next 2 months. Though the project focuses on families of children 0-5 years of age, all are invited to participate in the larger organizational change process through the Resilient Beginnings Collaborative. After the training, we will partner with Johns Hopkins University and pediatric safety net clinic coaches toward building more organizational resilience and trauma-informed practices. We are appreciative of your partnership in this collective transformation.

If you have questions about this training or would like more information about the Resilient Beginnings Collaborative, we encourage you to speak with your supervisor or a member of the RBC Core Team (Dr. Omowale Omotose, LCSW Gillian Fynn and LCSW Anne Rockwood).

Thank you for all you do,

[Director’s name and/or names of executive leadership staff e.g. Marty Lynch]
Trauma-Informed Care
Workforce Development

Elisa Nicholas, MD, MSPH, FAAAP
Chief Executive Officer

Resilient Beginnings Collaborative Convening
November 01, 2018
**Step One**
Capacity Building & Training in Trauma Informed Care

- EBBI Advisory Council
- EBBI Staff
- Clinic Leadership
- All Clinic Staff
- All Staff with Patient Contact

**Step Two**
Identify Target Population

- Prenatal Patients
- New Moms, Dads and Caregivers
- Children zero to four (0-4) years of age
- Caregivers of zero to four (0-4) years of age

**Step Three**
Screening

**For the Child**
- PEDS
- MCHAT
- Sensitive and Probing Questions

**For Parents/Prenatal**
- Family/Pregnancy Wellbeing Survey
- Sensitive and Probing Questions
- Edinburg Postnatal Depression Scale

**Step Four**
Assessment and Stratification

**High Risk**
- Intake Interview & Assessment which includes Patient Health Questionnaire (PHQ9) for depression, and the Generalized Anxiety Disorder Assessment (GAD7)
- Referrals & Linkage

**Medium Risk**
- Intake Interview & Assessment
- Referrals & Linkage

**Low Risk**
- Resources
- Referrals & Linkage

**Step Five**
Patient Care Plan Interventions

- Multidisciplinary Case Consultation
- Case Management,
- Medical Legal Partnership
- Home Visits
- Advocacy
- Resources

**Classes**
- Breastfeeding
- Cooking classes
- IPV Support Group
- Individual Therapy
- Infant Massage
- Parenting & Attachment
- Postpartum Depression
- Project Fatherhood
- Storytime
- Walking groups

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EBBI was made possible by a generous contribution from the Everychild Foundation
Workforce Development and Best Practices

• National Council for Behavioral Health (NCBH) Learning Collaborative Participation

• Two-day NCBH Training—Cheryl Sharp, MSW, ALWF and Karen Johnson, MSW, LCSW
  – Training with leadership
  – Training with all staff
  – Meeting with Everychild Bright Beginnings Initiative (EBBI) Advisory Group
  – Post training check-in with all sites

• Ongoing training to new staff
  – Integration of 2-hour training into new hire orientation
  – Motivational interviewing and peri-partum depression training for MD/NP
Workforce Development and Best Practices

• Clinical Provider Training
  – Recognition of signs and symptoms of trauma

<table>
<thead>
<tr>
<th>Child’s Response to Trauma: Misunderstood Causes in Young Children</th>
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<tbody>
<tr>
<td>Response</td>
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<tr>
<td>-----------</td>
</tr>
<tr>
<td>• Detachment</td>
</tr>
<tr>
<td>• Numbing</td>
</tr>
<tr>
<td>• Compliance</td>
</tr>
<tr>
<td>• Fantasy</td>
</tr>
<tr>
<td>• Females</td>
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<tr>
<td>• Children unable to defend themselves</td>
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</tbody>
</table>

Content source: The American Academy of Pediatrics Trauma Toolkit: The Medical Home Approach to Identifying and Responding to Exposure to Trauma
Workforce Development and Best Practices

• Clinical Provider Training
  – Recognition of signs and symptoms of trauma

<table>
<thead>
<tr>
<th>Response</th>
<th>More Common in</th>
<th>Misunderstood Cause</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypervigilance</td>
<td>Males</td>
<td>ADHD</td>
</tr>
<tr>
<td>Aggression</td>
<td>Witness to Violence</td>
<td>ODD</td>
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<tr>
<td>Anxiety</td>
<td>People able to fight or flee</td>
<td>Conduct disorder</td>
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<tr>
<td>Exaggerated Response</td>
<td></td>
<td>Bipolar disorder</td>
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<td></td>
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<td>Anger management difficulties</td>
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Workforce Development and Best Practices

- Clinical Provider Training
  - Recognition of signs and symptoms of trauma

<table>
<thead>
<tr>
<th>Child's Response to Trauma: Bodily Functions</th>
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<tbody>
<tr>
<td>Symptom(s)</td>
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<tr>
<td>:-----------</td>
</tr>
<tr>
<td>Difficulty falling asleep</td>
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<tr>
<td>Difficulty staying asleep</td>
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<tr>
<td>Nightmares</td>
</tr>
<tr>
<td>Rapid eating</td>
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<tr>
<td>Lack of satiety</td>
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<tr>
<td>Food hoarding</td>
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<tr>
<td>Loss of appetite</td>
</tr>
<tr>
<td>Other eating disorders</td>
</tr>
<tr>
<td>Constipation</td>
</tr>
<tr>
<td>Encopresis</td>
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<tr>
<td>Enuresis</td>
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</tbody>
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Workforce Development and Best Practices

• American Academy of Pediatrics (AAP) Toolkit
  – Paid provider staff for time to review
  – Topics Include
    • Adverse Childhood Experiences and the Lifelong Consequences of Trauma
    • Addressing Adverse Childhood Experiences and Other Types of Trauma in the Primary Care Setting
    • The Medical Home Approach to Identifying and Responding to Exposure to Trauma
    • Bring Out the Best in Your Children
    • When Things Aren’t Perfect: Caring for Yourself and Your Children
    • Protecting Physician Wellness: Working With Children Affected by Traumatic Events

• Continuing Medical Education (CME) (i.e. psychiatrists)
  • “The Healing Fields” Symposium on Trauma, Healing and Resiliency featuring psychiatrist Dr. Richard Mollica, Director of the Harvard Program in Refugee Trauma
Safe and Secure Environments

• Physical Safety
  – Implemented friendly, engaged security staff

• Personal and Emotional Safety
  – Ongoing training with staff regarding interactions that promote personal and emotional safety

• Environmental Setting
  – Tea & coffee
  – Renovations at acquired & existing sites
Patient Voice, Choice and Collaboration

- Recognition of relationship between staff morale/satisfaction and patient satisfaction
  - Employee Satisfaction Advocacy Team (ESAT)
  - Staff and patient satisfaction surveys that have integrated assessment of a trauma informed approach
  - Patient voice through consumer board member and EBBI advisory board members
- Recognition that screening of patients sometimes triggers secondary or vicarious trauma in staff
- Addressing issues through an equity and cultural lens in both patients and workforce
  - Special Populations in Long Beach
- Policy & procedures respect patient voice, choice, and collaboration
Early Screening and Comprehensive Assessment

• What Screening Tools & How to Implement

• SCREENING IS NOT THE END ALL, BUT IS A MEANS TO OPEN THE CONVERSATION

• How to help staff engage & open that conversation

• Role of trust & relationship
Early Screening and Comprehensive Assessment

• Challenges Faced Implementing a Trauma-Informed Approach
  – System—who, what, when, where?
  – Vicarious trauma
  – Staff discomfort with answers
  – Different personality types or styles of staff
  – Patient discomfort with surveys and questions
  – Potential triggering of staff and/or patients by questioning and/or questionnaire
Continuing the Journey: A Trauma-Informed Workforce

- Onboarding: 2-hour training
- All staff ongoing training at bimonthly meetings and e-learning
- Role of videos/presentation
- Stress reduction education/classes/books (*Stress Free for Good*)
- Supervision/Management Training
- Physician/Resident Education
- Policy & Procedure Revision
- Confirmed that EAP uses Trauma-Informed therapists
- Employee Health Insurance covers mental health
Taking the Trauma-Informed Approach to Workforce Beyond our Doors

• Changing the lens of the community
  – Instead of asking “What’s wrong with you?” ask “What happened to you?”

• Touching those who work with children and families
  – City Agencies
  – School District
  – Law Enforcement
  – Department of Child & Family Services
  – Health Department
  – Community Physicians
  – Community-Based Organizations
  – Faith-Based Organizations

• MHSA – LACDMH Innovation 2 Grant

• **Goal: Trauma-Informed and Resilient City and Beyond**
Adversity is not destiny

Love over violence
The Children’s Clinic
“Serving Children & Their Families”

Elisa Nicholas, MD, MSPH
Chief Executive Officer
(562) 264-3551
enicholas@thechildrensclinic.org
BREAK: 10 minutes
PICC Element #2: Key Perspectives, Strategies, & Tools for Assessing & Identifying Trauma & Resilience
Assessing and Identifying Trauma and Resilience: Tools and Strategies from the PICC Collaborative
Trauma-Informed Integrated Care

Primary Care

Family

Community

Mental Health
Weighted contributions to summary health outcomes

www.countyhealthrankings.org
No ideal “screener”

- Integrates range of primary care concerns
- High enough positive predictive value
- Helps differentiate possible conditions
- Accounts for disagreement among observers
- Valid across cultures/languages/literacy issues
But screening is helpful

• Systematizes process
• May create a value that can be tracked over time
• May be of use in assessing coverage of population
• Signposts site’s openness to discuss subject
• Give people time to prepare, process, before visit
**Goal 1. Understand Families' Assets and Risks**

- A. Partner with families to understand their family and community context
- B. Use appropriate and effective tools that examine risks, needs, and protective factors

**Goal 2. Engage Families Using Information Learned**

- A. Use results to engage and partner with all families
Thoughts?

• While trauma informed care offers an important lens to support young people who have been harmed and emotionally injured, it also has its limitations. I first became aware of the limitations of the term “trauma informed care” during a healing circle I was leading with a group of African American young men. All of them had experienced some form of trauma ranging from sexual abuse, violence, homelessness, abandonment or all the above. During one of our sessions, I explained the impact of stress and trauma on brain development and how trauma can influence emotional health. As I was explaining, one of the young men in the group named Marcus abruptly stopped me and said, “I am more than what happened to me, I’m not just my trauma”. I was puzzled at first, but it didn’t take me long to really contemplate what he was saying.

• The term “trauma informed care” didn’t encompass the totality of his experience and focused only on his harm, injury and trauma. For Marcus, the term “trauma informed care” was akin to saying, you are the worst thing that ever happened to you. For me, I realized the term slipped into the murky water of deficit based, rather than asset driven strategies to support young people who have been harmed. Without careful consideration of the terms we use, we can create blind spots in our efforts to support young people.

Examples from PICC

Element 4. Assess Whole Family Health and Resilience

- Prepare families for screening questions ahead of time (must be more than handing families a checklist with “loaded” questions)

- Identify and screen for social determinants of health in primary care

- Develop universal trauma-informed screening processes (e.g., questions asked by nurse when rooming; completing questionnaire in waiting room, etc.)

- Be prepared for reactions and responses (consider what and when questions might be triggering)

- Use the conversations around screens as an in-office intervention

- Use warm, real-time “hand-offs” and processes to respond to what families identify (e.g., social workers, Health Leads, food security access)

- Think broadly about the intersections between trauma-informed care, social determinants of health, racial justice, and equity
Pediatric Integrated Care Collaborative (PICC)
Improving Primary Care’s Capacity to Provide Whole Family Care in the Context of Community
An Example of a Tool: Adapted SEEK

Preamble

may be the
most
important
part!!!
Screening Related to Health Leads
Thanks
ACEs Screening in Pediatrics – Tips & Lessons Learned
Challenges to Universal ACEs Screening

- Lack of time
- Lack of provider comfort and fear of incorrect information
- Perceived negative patient reaction
- Concerns regarding strength of referral system
- Fear of clinic liability and increases in cases of mandated reporting
- Questions about tools and scientific foundation
- Perception that ACEs pertain to only certain populations
- Perception that ACEs are outside physician core function

Source: CYW Insights Research with Pediatricians, unpublished; Kecker et al., 2016
Easing Physician Anxiety

• ACE Screening is one tool to gauge risk and determine follow-up
  • Not all problems are going to be solved at one appointment!

• Often, the resources for intervention already exist at the clinic, they may just need to be re-organized
  • Look outside traditional behavioral/mental health for resources

• ACEs Screening enhances standard care by providing physicians with additional information, a tool for patient education and a way to identify and assist children who may have otherwise been missed
Making screening a reality in your practice

- Implement a Performance Improvement Project
- Get buy-in at all levels of the practice
- Incorporate into annual well-child visits
- Start with a pilot population
  - Starting with a smaller targeted population can help to get buy-in
- Bring EHR/IT team into the discussion early
Documentation in Patient Record

- Needs methodical planning of documentation with reporting and data analysis in mind
- Bring IT build representatives and report builders to the table during planning discussions
- Consider target population in discussions for report planning (visit type, age)
## Outcome and Performance Measures

<table>
<thead>
<tr>
<th>(1) % of patients screened</th>
<th>Numerator</th>
<th>The number of patients in a given month that were screened using an ACE questionnaire</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator</td>
<td>The number of patients in a given month that were eligible* for the ACE questionnaire (write out what definitions for eligible patients)</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>(2) % patients with positive ACE score</th>
<th>Numerator</th>
<th>The number of patients screened in a given month with a positive* ACE questionnaire score (write out definition for positive)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator</td>
<td>The number of patients in a given month that were screened using an ACE questionnaire</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(3) % patients positive ACE score patients that have appropriate referral</th>
<th>Numerator</th>
<th>The number of patients referred to additional services/resources related to positive ACE screen</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator</td>
<td>The number of patients screened in a given month with a positive ACE questionnaire</td>
<td></td>
</tr>
</tbody>
</table>
ACEs Screening Protocol Development

- Clear rationale for ACEs screening
- Population and screening intervals selected
- Identify screening tool to be utilized
- Outline scoring algorithm
- Develop education and intervention plan
Ex: Screening workflow

- Administer tool
- Assess for symptoms
- Determine follow up
- Linkages
Ex: Scoring Algorithm

Administer tool

Assess for symptoms

Determine follow up

Low Risk

Score of X

Provide education on ACEs and Toxic Stress

Intermediate Risk

Score of Y

Without symptoms

Provide education on ACEs and Toxic Stress

High Risk

Score of Z

With or without symptoms

Provide education on ACEs and Toxic Stress

Linkages
Clinical Symptoms

**Inflammatory Responses**
- Frequent asthma exacerbations
- Frequent eczema flaring
- Frequent colds
- Frequent infections such as ear infections or pneumonia

**Endocrine System Responses**
- Diabetes
- Difficulty keeping weight on
- Frequent abdominal pain
- Obesity
- Poor growth
- Constipation
- Weight gain or loss
- Difficult/irregular menses
- Early or late onset of menses/puberty

**Neurological System Responses**
- New onset, or recent increase in anxiety
- New onset, or recent increase in depression
- Enuresis/Encopresis
- Behavior problems- impulsivity, oppositional defiance
- Frequent headaches/migraines
- Inconsolable crying
- Difficulty sleeping or nightmares
- Disassociation/apathy
- Regular Drug, alcohol, tobacco use
- Risky sexual behavior- frequent sexual activity, multiple partners, lack of use of condoms/contraception
- Self-Harm –cutting, suicidal Ideation/attempt
- School problems- school avoidance, frequent absence, poor/failing grades
- Learning problems- increase in ADD, ADHD symptoms
Referrals & Interventions – 3 Tiers

• Clinical Response
  o Early detection through screening
  o Patient Education
  o Anticipatory Guidance
  o Screen = intervention = increased rapport
  o Clinical management & considerations using an ACEs lens

• 6 Domains of Intervention (sleep, nutrition, exercise, mindfulness, mental health, and healthy relationships)
  • Prompt therapeutic interventions & enhancing protective family factors

• Additional intervention supports
  • Modifiable factors (housing, food, etc)
  • Parenting support

Adapted from Bucci et al. Toxic Stress in children and adolescents. Advances in Pediatrics, 2016
Anticipatory guidance, specific to the age of the patient, includes information about the benefits of healthy lifestyles and practices that promote wellness, coping with a chronic disease, or prevention.

Anticipatory guidance topics can be used as prompts to ask open-ended questions so that the parent and physician can have a timely, relevant, and appropriate discussion that meets everyone’s needs. The following Anticipatory Guidance handouts are available on the NPPC website:

- Building Resilience
- Nutrition and Exercise
- What is ACEs Screening?
- Toxic Stress
- Self-Regulation
Adverse Childhood Experiences (ACEs)

Did you know that Adverse Childhood Experiences can be harmful to your child’s health?
- Adverse Childhood Experiences (ACEs) can cause harm to a child’s developing brain and body, influence behavior and learning, and lead to mental health problems.
- These long-term changes, in the absence of supportive caregivers, are called toxic stress.
- Everyone is built differently. Some need more support than others.

Adverse Childhood Experiences as identified in the ACEs study are listed below:
- Parental separation or divorce
- Incarcerated household member
- Domestic violence
- Living with someone who is chronically depressed, institutionalized, or suicidal
- Alcohol/drug abuse in the home

In addition we believe these things can lead to toxic stress:
- Life-threatening illness/injury
- Chronic illness
- Community violence
- Harassment, emotional/sexual/physical violence

Health begins with hope!
People can cope with challenging events in their lives by creating a circle of wellness that includes using support systems, owners, good nutrition, and regular medical care.

Toxic Stress

Positive Stress:
- Short-term increases in heart rate, respiratory rate, and blood pressure
- More rapid or shallow breathing

Tolerable Stress:
- Temporary rise in stress hormones, but support by caregiver

Toxic Stress:
- Persistent activation of stress response systems in the absence of protective relationships, resulting in stress responses, behavior, and physiological systems

How stress affects the human body:
- Headaches, feeling burnt out, lack of energy, irritability, restlessness, anger, insomnia
- Muscle tensing, muscle aches, digestive issues
- Heart attack and heart issues
- Headache, neck pain, and muscle tension
- Mood swings, anxiety, increased risk of substance abuse

Support systems:
- Programs, support groups, counseling, therapy, medication
- Education, community, family, friends, pets

Contact information:
- Center for Youth Wellness
  Phone: 415-692-6233
  Website: www.encyw.org

NPPC
- National Parenting Information Center
  Phone: 877-458-2655
  Website: www.nppo.org
What's Toxic Stress?

www.stresshealth.org
Questions?
Thank you!

Rachel Gilgoff, MD, CCTP, FAAP
rgilgoff@centerforyouthwellness.org
Team Presentations:
How are you identifying trauma and resilience, including tools used, challenges encountered, and recommendations for others?
A cloud based innovative solution that empowers patients, care teams and their communities to collaboratively address social determinants of health
FINDconnect FEATURES

- Customizable, validated survey algorithms
- Web based platform, will run on any modern browser
- Sophisticated real-time resource matching
- HIPAA-compliant case management
- Automated action planning
FINDconnect GOALS

To make connecting with resources for social and environmental determinants of health incredibly easy and effective for all

Suite of Tools
- Opportunity Assessment
- Action Plan creation and delivery
- Knowledge Base
- Case Management

Automation provides
- Scalability
- Outcome tracking
- Program quality and evaluation

Training & Education
- Integrating into clinic flow
- User guide
- Cultural humility when addressing SDOH
FINDconnect Screening

Opportunities Assessment
- Research Enrollment
- Resiliency Screening
  Issues that concern parent and family – housing, food, med-legal, activities, etc.

Child Development (ASQ, MCHAT)

Adult Mental Health
- PHQ2 and PHQ9
- GAD7
- ACE Screen

Child Mental Health
- Pediatric Symptom Check List (by age groups)
- ACE Screen
Action Plan

After completing the needs assessment survey, the caregiver is presented with a custom tailored action plan that lists resource recommendations based on their three priority needs identified. The detailed information provides an easy to follow guide for caregivers to immediately act upon once leaving the FIND desk.
What’s Working?

- Standard of care in primary care clinic
- Support enrollment into research studies associated with ACEs, SDoH
- Regular updates to resource database
- Data collection and geo-mapping
- Care coordination
- Increased patient satisfaction
- Reduced stress and burden among clinic staff
Opportunities for Growth

- Available resource across BCHO
- EHR Integration in progress
- Conversations with other clinics (local/national) for expansion outside BCHO
- Expanding to shared knowledge base
- Community facing portal is under-utilized → Orgs can access resources in system, maintain, and get utilization data on referrals
- Patient facing portal (Caregiver) is under-utilized
Lessons Learned

- Know your contracts
- Utilize internal IT support
- Cultural shift takes time
RBC BCHO TEAM

- Maoya Alqassari
- Mindy Benson
- Karen Daley
- Larissa Estes
- Lourdes Juarez
- Dayna Long
- Shelly Nakaishi
- Saun-Toy Trotter
Team Presentations:
How are you identifying trauma and resilience, including tools used, challenges encountered, and recommendations for others?
Assessing for Trauma in our Early Childhood Population
An initiative of
Marin Community Clinics
Pilot Site
National Pediatric Practice
Community on Adverse
Childhood Experiences (NPPC)

An initiative of CENTER FOR
YOUTH WELLNESS
health begins with hope
Vision for the Project

• To identify patients at-risk as early as possible, including in utero, in order to intervene early and prevent additional ACEs

• Our goal is to prevent ACE’s from occurring before the child is born, and be able to follow families from prenatal care through early childhood to ensure they have the resources they need
Development of ACES Screen

• Pilot project in conjunction with Center for Youth Wellness
• 6 month pilot, April – October 2018
• Developed Screen based on CYW prototype, with modifications to better fit our population
• De-identified, but with clear demarcations to increase clarity while maintaining confidentiality
Many children experience stressful life events that can affect their health and wellbeing. The results from this questionnaire will assist your child’s doctor in assessing their health and determining guidance.

Please read the questions below. COUNT the number of questions you would answer “YES” to and write the TOTAL NUMBER in the box. Please DO NOT mark or indicate which specific questions apply to your child.

<table>
<thead>
<tr>
<th>Question</th>
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</thead>
<tbody>
<tr>
<td>*Has your child ever seen or heard adults in the home pushing, hitting, or threatening to hurt each other?</td>
</tr>
<tr>
<td>*Has anyone ever touched your child’s private parts in an inappropriate way or hurt your child physically?</td>
</tr>
<tr>
<td>*Has anyone insulted, swore at, threatened or otherwise acted in a way that significantly scared or upset your child?</td>
</tr>
<tr>
<td>*Does your child have any family members with anxiety, depression, PTSD or other mental health concerns?</td>
</tr>
<tr>
<td>*Does your child have any family members who have or have had a problem with alcohol or other drugs?</td>
</tr>
<tr>
<td>*Has your child ever been separated from either parent due to parental illness, divorce, incarceration, immigration problems, foster care or other issues?</td>
</tr>
<tr>
<td>*Has your child ever went without food, clothing, a place to live, or had no one to protect her/him?</td>
</tr>
</tbody>
</table>

**What are ACES?** Adverse Childhood Events (ACEs) are stressful or frightening things that happen during childhood, such as abuse, neglect, or severe dysfunctions in the household. We know that people who experience a lot of ACEs may have more problems with their health.

**What is resilience?** Resilience is the ability to bounce back from stressful situations. Children inherently have some degree of resilience and resilience can also be learned, practiced and improved upon. Some studies have shown that good resilience skills can help people avoid the health problems that come from ACEs exposure.

**Why does my pediatrician want to know this information?** Knowing what sorts of experiences your child may have been through will help us to know how to support and guide you through your parenting journey.

Reviewed By: _______________________  
Date: ______________
Pilot Focus-Pediatrics

- 9 mos. Well Baby Visit
- 30 mos. Well Child Visit
- All new patient visits under 12 yrs.
- MA administers the screen, PCP reviews screen and discusses with patient/caregiver
- 3 clinics, 9 providers for pediatric screens
Pod MA gives ACES screen to parent at start of visit. Introduces concept of ACES and why we’re screening.

PCP reviews results of screen. Asks parent if anything they would like to discuss re: their response.

IF:
- ACE Score 0-1, no symptoms
  - MA provides info on ACES, offers services if parent wants. If parents yes - care navigator links to services.
- ACE score 2+, or current symptoms
  - Care Navigator provides info on ACES, finds out what services pt/parent would benefit from, and links to services (ie. BH, Triple P, Health Hubs, Legal, etc)
- Parent requests services
  - Care navigator provides info on ACES, finds out what services parent/pt would benefit from, and links to services.
Care Navigation Referral Flow Chart for ACES Screening

- **Care Navigator provide info on ACES and determines what current needs are (can use ACE Script if like)**
  
- **ACE score 0-1, no symptoms**
  - Provide information on ACES and offer services if interested

- **ACE score 1 with symptoms, or ACE Score 2+**
  - Weight/Food/Exercise Concerns - Offer Nutrition Referral
  - Behavior Changes - Offer Triple P Parenting Group and/or BH appointment
  - School Issues - BH appointment or Development appt
  - Sleep Issues - Offer Triple P Parenting Group on Sleep and/or BH appointment

- **Any significant BH Concerns: BH appointment, group referral or Warm Hand Off as indicated**

- **Parent interested in services for themselves**
  - Referrals: Stress Management Group, Anxiety/Depression Group, Triple P Parenting Group or individual BH appointment
Pilot Focus-OBGYN

- All High Risk OB patients
- Incorporated into our psychosocial assessment of High Risk OB patients through the CPSP Program
- CPSP Administers screen and discusses results with patient
- 1 clinic, 3 CPSP providers for OB screens
Results

• 149 Pediatric Patients Screened
• 50 Obstetrics Patients Screened
• 19 positive ACES Screens (2+) in pediatrics
MCC ACEs Screening

Pilot Findings April-September

- % Screened: 53% Yes, 47% No
- % Positive: 85% Yes, 15% No
- % Referred: 74% Yes, 36% No
In your opinion, on a scale of 1-10 how USEFUL did you find the ACEs screener? (For example: did you get answers that were surprising or unexpected?)

7 responses
In your opinion, how often were you able to get or find the resources for your patient that you felt you needed after reviewing the ACEs screener? (ex: you were able to contact a patient care navigator for a warm hand-off)

7 responses
Lessons Learned

• In process of collecting data - preliminary results
• Overall very positive feedback
• Used as a tool to help identify needs of more patients, not a validated measure
In your opinion, on a scale of 1-10, how EASY was it to screen for ACEs using the current paper screener?

7 responses
What were the BARRIERS to using the ACEs screener?

7 responses

- Not enough time to review or address it: 1 (14.3%)
- Remembering to give it: 5 (71.4%)
- Patients would not fill it out: 0 (0%)
- Not feeling comfortable answering questions: 0 (0%)
- Unable to find it when needed: 0 (0%)
- None: 2 (28.6%)
Which of the following options would make it EASIER to use the ACEs screener?

6 responses

- If the screener was electronic: 0 (0%)
- If there was a care guideline reminder: 5 (83.3%)
- If there were regular announcements to clinic personnel: 1 (16.7%)
- If there was a huddle before clinic to discuss: 2 (33.3%)
- If someone other than the MA were to give the CE: 1 (16.7%)
Next Steps

• Plan to bring to scale clinics-wide
• Incorporating into EHR, ideally into a more comprehensive screen of social determinants of health
• Identified need of systemized way of tracking referrals
LUNCH: 45 minutes
Potential Topic Areas

1. What comes next after a positive screen?
2. Getting buy-in from frontline staff and providers
3. Working to engage families in the assessment process
4. ???
5. ???
6. ???
PICC Element #2: Assessing & Identifying Trauma & Resilience Breakout Groups
Potential Topic Areas

1. What comes next after a positive screen?
2. Getting buy-in from frontline staff and providers
3. Working to engage families in the assessment process
4. ???
5. ???
6. ???
Evaluation Updates: Sharing & Discussing Results from the Baseline Assessment
Reminder: Evaluation goals

Assess impact of the initiative

Provide real-time feedback to inform technical assistance & program support

Identify lessons learned to ensure better care & support for kids and families experiencing trauma
## Reminder: Data collection

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<thead>
<tr>
<th></th>
<th>Q3 2018</th>
<th>Q4 2018</th>
<th>Q1 2019</th>
<th>Q2 2019</th>
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<th>Q4 2019</th>
<th>Q1 2020</th>
<th>Q2 2020</th>
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<tbody>
<tr>
<td>Baseline &amp; Follow-Up Assessment</td>
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<td>Organizational Data Reporting Progress Reporting</td>
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RBC Organizational Assessment

Assessment Domains

- Understanding and confidence in trauma and resilience informed care
- Buy-in and commitment for trauma and resilience-informed care
- Support for staff and providers
- Trauma and resilience-informed office environment
- Clinical practices that assess childhood adversity
- Clinical practices that address childhood adversity
- Patient and family engagement
- Systems, practices & partnerships to create coordinated systems of care
- Learning and improvement regarding trauma and resilience-informed care

PICC Elements

- Office environment
- Assess health
- Address health
- Family engagement
- Community relationships & Coordinate
Assessment Results: Journey to becoming a healing organization

Trauma organized organization induces trauma by being reactive, is fragmented, avoids and numbs, has authoritarian leadership, and perpetuates inequity and an us-versus-them mentality.

Trauma informed organization understands the nature and impact of trauma and recovery, has shared language, and recognizes socio-cultural trauma and structural oppression.

Healing organization reduces trauma by being reflective, makes meaning out of the past, is growth and prevention oriented, is collaborative, values equity and accountability, and has relationship leadership.

RBC average = 4.86
Assessment Results: PICC framework

- **OFFICE ENVIRONMENT**: 7
  - Working on it but need support

- **COMMUNITY RELATIONSHIPS**: 1/6
  - Working on it and making progress

- **FAMILY ENGAGEMENT**: 3/4
  - Well-established and regularly monitor

- **ASSESS HEALTH**: 3/3/1

- **ADDRESS HEALTH**: 3/4

- **COORDINATE**: 3/4

Center for Community Health and Evaluation | www.cche.org
Assessment Results: Domain ratings

Understanding & confidence
Buy-in & commitment
Support for staff & providers
Physical office environment
Clinical practices that assess
Clinical practices that address
Coordinated systems of care
Patient & family engagement
Learning & improvement
### Potential common metrics

<table>
<thead>
<tr>
<th></th>
<th>Screening</th>
<th>Referral</th>
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<tr>
<td><strong>Relevance</strong></td>
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<td><strong>Feasibility</strong></td>
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<td><strong>Usefulness</strong></td>
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- **Very**
- **Somewhat**
- **Likely**
- **Maybe**
- **Unlikely**
- **Useful**
- **Unsure**

**Other areas teams are interested in evaluating:** Changes in staff knowledge, confidence, involvement; Assessing patient impact & experience; Understanding, familiarity with community resources
Data placemat activity

**Goal:** Discuss the assessment results as a team to understand current state and identify opportunities

Buy in and commitment
Support for staff and providers
Clinical practices that assess (i.e., screening)

**Discussion questions:**
- What insights does this provide about your organization?
- What surprised you? What questions does this raise?
- Where do you hope to make progress during RBC?
- What are potential actions or next steps?
Spokesperson for each team shares one reflection from the discussion of the assessment results
BREAK: 15 minutes
Team Time

Using the results of your baseline assessment & driver diagram, reflect on your team’s next steps:

1. What two PICC elements do you want to focus through the end of Q1?

2. What are your top 3-5 ideas for action? **See the PICC framework for inspiration**

TIPS:

• Start small. Don’t feel like you need to accomplish everything all at once.

• Prioritize your ideas & be realistic about what is possible. Build on what you are already doing.

• Utilize the faculty in the room when you get stuck.
Team Time Worksheet

Use this worksheet to help plan your next steps. Please write legibly; CCI will be collecting this and emailing your team a scanned copy to you.

**TWO CORE ELEMENTS**

Circle which two elements you’d like to prioritize your efforts through the end of Q1 2019.

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<tr>
<td>Office Environment</td>
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<td>Family Engagement</td>
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<td>Address Health</td>
<td>Coordinate</td>
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**ELEMENT #1:**

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<tr>
<th>Ideas for Action</th>
<th>What’s your first step?</th>
<th>Completion Date</th>
<th>Who Needs to be Involved?</th>
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What support do you need from CCI or your organization to be successful in making progress on the two elements you’ve identified by the end of Q1 (March 2019)?

1.  
2.  
3.  
Looking Forward: Early Partnership Success Stories
Community partnerships to address social determinants of health

2. Build Relationships with Communities to Support Families
Team Presentation:
What are you doing & lessons learned?

West County Health Centers
Caring for our Communities
A California Health Center
Early Partnership
Health & Education
West County Health Centers
Our Unique Partnership

• 10 years of collaboration through Health Action and Cradle to Career Committee

• Communication based school boards, relationship with board members

• Employees who have either graduated from or have children at Guerneville School

• Strong sense of community fostered through 40 years of working together

• WCHC is the only healthcare organization out and Guerneville School is the only School District in the lower Russian River Area.
ROOTS Program

- **Addressing Absenteeism**
  - GSD has the highest Absenteeism Rates in Sonoma County
  - School success has a strong correlation with healthy development.
  - Students who miss more than 10% of school for any reason (chronic absenteeism) have less success in school

- **Our approach**
  - Create successful data sharing and;
  - Use Human Centered Design & Systems Thinking to understand the factors that influence absenteeism and;
  - Create successful solutions together.
Discovery Kit | Human Centered Design Method

- The Discovery Kit helps us **uncover the narrative** by moving beyond the obvious and helps us understand the underlying needs and causes.
  - Uncover the narrative by coding each interview
  - Use Human Centered Design to translate coded quotes into insights.
What we learned
What we learned – Quotes

“I see panicky kids that sometimes are hording food. When we have a party at school some of these kids make an extra plate for their sibling that’s in another class because they know they might not have food that evening.” ~ Teacher

“In my 30 years of teaching the thing that makes me the saddest because I am coming up on the end of my career, is, while I’ve seen improvements in some materials and programs the bottom line is that we still don’t have money for things that really matter. We don’t have the money for counseling and nursing and health programs. I’ve got a kids that walk in the door in the morning who I’m expecting to learn but the reality is that they might have had a rough morning, they may be homeless or with a foster family and this is their 4th school this year, they probably haven’t had breakfast and is too late for our school breakfast, there is substance abuse in their home and they have so much emotional stuff going on that for me to expect these children to learn is really difficult.” ~ Teacher

“For our entire K – 8th grade school we have one counselor that is shared between two other schools. And I just heard that her position will be cut back by 10% this upcoming school year.” ~ School Administrative Assistant
RBC Program

- **Discovery Kit Findings**
  - Trauma and;
  - The need for more behavioral / mental health resources for students and parents.

- **RBC Program**
  - As we gained these insights we had just been awarded the RBC grant
  - This partnership once again *just made sense*

- **TIC Training for RBC Program**
  - We invited Guerneville School Teachers & the Principle to participate in our TIC All Staff Training.
    - We knew from our insights that as a community we needed to build capacity and share a common language around trauma informed care so we can **together**, better serve our patients / students and their families.
Next Steps

• **Student Success Collaborative Workgroup**
  • As a part of this program we have established a monthly meeting with a subset of our core team, CMO and Guerneville School’s Superintendent
  • **Goal**
  • Use human centered design to create and implement strategies and interventions that will support parents and address childhood adversity. (*EXPLORATION PHASE*)
Lessons Learned

• It takes time – Working with another partners timeline can be challenging
• Develop a strategy & vision together early on
• Systemic change is hard work
• Communication and monthly check in meetings are necessary
• Building relationships & trust is important – Discovery Kit gave us this opportunity
• Being part of the community matters – employees graduated GSD and/or have children currently attending GSD
Partnership Inventory Activity

Activity

Get a flip chart paper. With your team, identify:

1. Top 3 partners in this work
2. One partnership you’d like to strengthen or develop
3. One area where there is a gap

You have 10 minutes.

Report Out

Each team shares:

1. 1 top/strong partner
2. 1 gap
In-Person Opportunities

- Session #1: June 12, 2018 (half day)
- Session #2: Nov. 2018
- Site Visits: Jan-April 2019
- Session #3: May 2019
- Session #4: Nov. 2019

Remote Support

- Webinar #1: July 2018
- Webinar #2: Oct. 2018
- Webinar #3: Jan. 2019
- Webinar #4: April 2019
- Webinar #5: July 2019
- Webinar #6: Oct. 2019
- Webinar #7: Jan. 2020
- Webinar #8: April 2020

Coaching Calls

Key Phases & Program Activities

- **Phase #1:** Build team, Collect baseline data. Complete org-wide TTC training. Develop action plan. (June-Nov 2018)
- **Phase #2:** Co-design with partners & patients; Test & implement elements; (Dec. 2018-Nov. 2019)
- **Phase #3:** Document workflows & protocols; Reinforce partnerships; Build resources; Spread lessons (Nov. 2019-May 2020)

- Release RFA (3/28/18)
- Info Webinar (5/25/18)
- Announce Cohort
- Access to Technical Assistance
- Final evaluation activities
Communication Tools

Monthly Newsletter

Calendar invites for big events

CCI Program Portal Page

https://www.careinnovations.org/rbc-portal/
**To-Do’s**

**CCI**
- All materials will be posted to network portal
- We will share information about the site visits in late December or early January.

**RBC Teams**
- Continue to work on your team’s action plan. Use it in your November & December coaching calls.
- Send a final copy to Angela by December 15.
- Work with CCHE to start collecting metrics.
Resilient Beginnings Collaborative (RBC)
Convening
Thursday, November 1, 2018

Thank you for completing the following survey. Your responses are confidential and will be analyzed collectively with other participant responses. Aggregate data are used to provide the RBC Support Team with feedback regarding the quality of the meeting and collective benefit to the participants.

1. On a scale of 1-5, please select the number below that best represents your overall experience with today’s meeting:
   - 1 = Poor
   - 2 = Fair
   - 3 = Good
   - 4 = Very Good
   - 5 = Excellent

2. Please select the number below that best represents your response to the statement: The meeting today was a valuable use of my time.
   - 1 = Strongly Disagree
   - 2 = Disagree
   - 3 = Neutral
   - 4 = Agree
   - 5 = Strongly Agree

3. The meeting was well organized:
   - Strongly Disagree
   - Disagree
   - Agree
   - Strongly Agree

4. The level of participant interaction/engagement in the meeting was:
   - Not enough
   - About right
   - Too much

5. I made connections today with other teams that will strengthen my organization’s RBC efforts:
   - Strongly Disagree
   - Disagree
   - Agree
   - Strongly Agree
   - N/A (not a team member)

6. To what extent did you find the sessions useful?

<table>
<thead>
<tr>
<th>Before lunch</th>
<th>Not useful</th>
<th>Somewhat useful</th>
<th>Useful</th>
<th>Very useful</th>
<th>N/A – Did not attend</th>
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<th>After lunch</th>
<th>N/A – Did not attend</th>
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7. What was the most valuable part of the meeting?

8. Please provide any suggestions for how the meeting could be improved.

Thank you for completing this survey!
Thank you!

For questions contact:

Megan O’Brien
Value-Based Care Program Manager
Center for Care Innovations
mobrien@careinnovations.org

Angela Liu
Program Coordinator
Center for Care Innovations
angela@careinnovations.org