RESILIENT BEGINNINGS NETWORK: FINAL EVALUATION REPORT

Center for Community Health and Evaluation
February 2024

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Resilient Beginnings Network: Final evaluation report
Executive Summary
February 2024

Initiative background

A growing awareness of the impact of trauma on people's health and wellbeing has underscored the need for trauma-informed and strengths-based approaches in working with patients and communities. Resilient Beginnings Network (RBN) was a three-year learning program that launched in November 2020, dedicated to advancing pediatric care delivery models that are trauma- and resilience-informed. RBN was led by the Center for Care Innovations (CCI) with funding support from Genentech Charitable Giving. It supported 15 safety net organizations in California's San Francisco Bay Area.

RBN structured trauma- and resilience-informed care (TRIC) work into four program domains as potential entry points for participating teams and articulated three cross-cutting themes affecting all TRIC work.

Program domains

Organizational environment	Establishing or deepening a trauma-informed and healing-centered clinic and organizational environments, including improved support for staff wellbeing
Prevention & promotion	Promoting resilience and protective factors among young children and their families that can lower the risk of developing physical and mental illness linked to trauma and early childhood adversity
Clinical practices	Testing, implementing, and spreading clinical practices to prevent, identify, respond to, and heal trauma and early childhood adversity
Community partnerships	Building and strengthening community relationships so that referrals and coordination efforts meet community, patient, and family needs

| Equity and racial justice | Strengths-based approaches | Patient & family engagement |

Cross-cutting themes

Trauma- and resilience-informed care refers to care in which all parties involved recognize and respond to the impact of traumatic stress and resiliency factors on children, caregivers, and service providers.

(adapted from **SAMHSA**)

RBN program elements
Participating teams received:
- A range of training & technical assistance (e.g., virtual learning sessions, individualized coaching)
- Structures for peer learning
- Site visits to organizations implementing trauma- and resilience-informed care
- $120,000 in grant funding

RBN took a holistic and integrated approach, including centering **dignity and equity** through Vital Village's Dignity Framework as a core component of all aspects of the program and presenting TRIC as a **long-term effort to shift mindsets, practice, and culture** within health care organizations.

RBN was influenced by several contextual factors presenting new opportunities and exacerbating challenges for an already stressed health care system. These included the COVID-19 pandemic, a national racial justice reckoning, increasing levels of hate focused on the Asian population, and climate catastrophes. These occurred alongside unprecedented investment in TRIC activities related to ACEs (adverse childhood experiences) screening and response, largely through California's ACEs Aware Initiative.
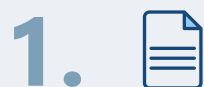
Methods

The RBN evaluation aimed to **promote learning** by 1) assessing changes in organizational capacity to implement TRIC and documenting teams' progress and lessons learned; and 2) understanding RBN's contributions to changes and progress. The evaluation used mixed methods to collect and analyze data. Key data sources included: an organizational capacity assessment, interviews with RBN teams, RBN participant survey, reflections from RBN faculty, document review, and observation of program events. The evaluation was conducted by the Center for Community Health and Evaluation (CCHE).
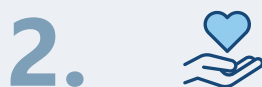
Evaluation findings

Based on analysis of these data, the evaluation identified several key findings related to teams' work in RBN and the program's contribution to progress and learning.
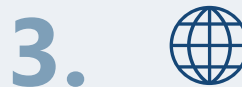
WHAT HAPPENED – Key findings on RBN outcomes

1.

ACEs screening continues to be a concrete entry point for teams seeking to advance trauma- and-resilience-informed pediatric care and is more effective when situated alongside other foundational efforts that support administration and response.

2.

RBN elevated **staff and provider wellbeing** as a key tenant of TRIC and most RBN teams engaged in a variety of activities to strengthen organizational practices supporting staff and providers during a time of immense stress on the health care system. Scope and frequency of these efforts varied.

3.

In addition to sustainable progress in discrete TRIC strategies, RBN began to shift broader **clinic culture** to be more trauma- and resilience-informed.

WHAT IT TAKES – Key findings on RBN learnings

4.

RBN's **flexible approach** in meeting teams where they were at, combined with a longer, 3-year program timeframe, allowed teams to shift work to apply new knowledge and capitalize on emergent opportunities.

5.

Teams reported increased awareness and understanding about the connection between **equity and racial justice** and TRIC. It took time to start to translate that learning into concrete efforts.

6.

Internal and external supports and structures contributed to teams' ability to advance TRIC in their organization, even in the face of significant, systemic challenges.

WHAT HAPPENED – Key findings on outcomes from RBN

1 **ACEs screening** continues to be a concrete entry point for teams seeking to advance trauma- and-resilience-informed pediatric care and is more effective when situated alongside other foundational efforts that support administration and response.

ACEs screening was the most common intervention that gained traction within RBN due to the tangible nature of the strategy and the supportive policy environment for ACEs screening in California.[1] **RBN was unique from other ACEs screening programs in that it was situated within a larger context of trauma- and resilience-informed organizational cultures of care, which generally helped to strengthen screening practices.** This included:

- **An increased focus on the process (the how) of screening and response** that supported the patient, family, and staff involved in the process. This helped ensure that screening was helpful and not harmful.

- **Integration of strengths-based approaches and resilience messages** as part of screening.

- **More holistic care** through in-visit screening discussions that helped care teams shift their mindset to see patients and families with more empathy, as whole people, and better address relevant needs.

- **Elevating and reinforcing the importance of foundational organizational work related to TRIC,** including strengthening organizational environments to be more trauma- and resilience-informed prior to implementing ACEs screening so they are more supportive of both patients and staff.

- **Improvements in referral relationships and practices** to follow up and close the loop on patient referrals to community resources.

- **Integration of a case manager or care coordinator position to support the screening process**, ensuring both staff and patients have the support they need throughout the screening process. See CCI's feature articles on two RBN teams testing this strategy for more information: How One California Clinic Tapped a Bilingual Medical Assistant to Lead ACEs Work and Pediatric Care Coordinators: Closing the Loop to Help Children at Risk Thrive.

See the Resilient Beginnings: Trauma-and-resilience-informed ACEs screening and response learning brief for additional details.

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[1] A state policy change prior to RBN provided reimbursement for ACEs screening for patients enrolled in Medi-Cal (California's Medicaid program). As a result, the state funded training and other resources that prompted safety net organizations across the state to prioritize ACEs screening implementation.

2 RBN elevated **staff and provider wellbeing** as a key tenant of TRIC and most teams engaged in a variety of activities to strengthen organizational practices supporting staff and providers during a time of immense stress on the health care system. Scope and frequency of these efforts varied.
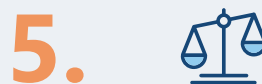
Supporting staff and provider wellbeing was a unique and important aspect of RBN. The program **prompted recognition of the importance of this work by explicitly shining a light on the people providing care and modeling reflective and wellness practices.** This was particularly applicable in the context of COVID-19 exacerbating stresses on the health care system and contributing to workforce burnout and staffing challenges (e.g., turnover, shortages). Common efforts related to staff and provider wellness included:

> *"I would say you've got to start with your caregivers, resource your caregivers. Because if you want them to be able to pour into your patients you've got to pour into them first."*

- **Bringing staff together** within and beyond the clinic (e.g., all-staff meetings, retreats).

- **Implementing wellness** activities (e.g., mindfulness practices, Moments of HOPE).

- Creating a **more supportive clinic space** (e.g., community boards, No Hit Zones).

- Collecting **feedback on staff and provider experience** including administering staff and provider surveys or conducting staff journey mapping.

Teams reported ongoing challenges carving out time to do this work particularly given competing priorities and the broader culture of health care. This CCI feature story provides additional information about one RBN team's work supporting staff and provider wellness.

3 In addition to sustainable progress in discrete TRIC strategies, RBN began to shift broader clinic culture to be more trauma- and resilience-informed.

Beyond each team's specific strategies, **RBN provided opportunity for organizations to grow in every aspect of being trauma- and resilience-informed.** In the RBN organizational capacity assessment, average ratings of all program domains and cross-cutting themes increased from the beginning of RBN (between 0.63 and 0.77 on a 5-point scale). This speaks to the broader influence of RBN concepts and practices beyond the individual strategies teams worked on, signaling the beginnings of wider shifts to clinic culture. Key examples included:

- **Building a common language** and perspective on trauma- and resilience-informed systems and care.

- **Changing how people work with each other** and with patients such as framing patient care around strengths and developing self-awareness and vulnerability with teammates.

- **Reorienting to new ways of thinking** (e.g., shifting from "What are you going to stop doing?" to "What do you like to do already that benefits your health?").

Two key RBN strategies contributed to these changes in organizational culture:

- **Training and education** that exposed participants to new concepts, raising awareness and understanding of trauma- and resilience-informed approaches, often reaching clinic team members not participating in RBN. See CCHE's TRIS Training Topical Learning Brief for more detail.

- Efforts to **elevate the voices of patients, families, and community** partners, which allowed the experiences of people outside the clinic walls to influence what happens within them.

WHAT IT TAKES - Key findings on RBN learnings

Integrating trauma- and resilience-informed approaches into pediatric care organizations is long-term, complex, culture change work. It affects all aspects of a health care organization and demands that clinic providers and staff do their work differently. There were several aspects of RBN's design that contributed to the overall effectiveness of the program.

4 RBN's **flexible approach** in meeting teams where they were at, combined with a longer, 3-year program timeframe, allowed teams to shift work to apply new knowledge and capitalize on emergent opportunities.

RBN's program design effectively met teams where they were in their journeys to be more trauma- and resilience-informed. As a result, there was variation in what teams focused on and how much that changed over the three years. **Teams worked meaningfully on between 1 and 5 strategies** during the program and several teams reported notable accomplishments from emergent opportunities that were unrelated to goals they articulated early in the initiative. For example, relatively few teams started with clear, concrete goals related to the cross-cutting themes but more teams than had goals reported traction in each of the themes by the end of RBN.

While RBN's design overall benefitted teams, it came with a few complications or challenges that had to be mitigated.

Benefits	Trade-offs
• **Broad and nonprescriptive** – intentionally built to be inclusive of a range of activities • **Flexible** so teams could test, adapt, and evolve—particularly important for operationalizing the cross-cutting themes • **Longer timeframe** and **slower start** allowed for relationship and trust building, as well as priority identification and goal setting • **Suite of program supports** provided teams multiple options for resources to help them move work forward	• Limitations to the depth of content delivery and peer exchange • Some teams struggled to get started and wanted more specific direction • Having foundational activities be optional resulted in lower uptake and fewer teams having that in place

5 Teams reported increased awareness and understanding about the **connection between equity and racial justice and TRIC**. It took time to start to translate that learning into concrete efforts.

RBN intentionally elevated racial justice as a necessary piece of TRIC and provided several resources to support teams in doing this work. Some teams reported that while their mission and values aligned with the equity focus, they did not know how to translate that into action. Despite challenges, over half of teams reported equity-related changes by the end of RBN including:

- Conducting equity-related **trainings**.

- Prompting **mindset shifts**, such as better understanding of personal biases and positional power, as well as acknowledging different patient experiences based on race.

- Implementing **new policies and practices**, including collecting and using race and ethnicity data for quality improvement purposes.

- Attending to **language accessibility** by hiring bilingual staff, translating materials, and setting up bilingual patient advisory boards.

6 **Internal and external supports** and structures contributed to teams' ability to advance TRIC in their organization, even in the face of significant, systemic challenges.

Internal and external factors supported teams' progress in their chosen RBN strategies despite two commonly reported challenges impeding TRIC work: time constraints and workforce issues (e.g., turnover, staff shortages). Four primary factors contributed to advancing TRIC work in RBN:

A **clear and realistic scope** for the RBN effort. More successful teams determined a clear scope of influence for their work (i.e., where they had some control or decision-making power) and built from there.

A **multi-disciplinary team with effective leadership**. Teams reported benefits bringing together perspectives across disciplines and roles and providing a space for honest dialogue and support.

Organizational leadership engagement and support. Teams progressed faster when they had the involvement of organizational leaders who had the power to move things forward and free up staff time for this work.

RBN program supports. Participant feedback on the RBN program overall was consistently positive and teams generally found the most value in the virtual learning sessions, individualized coaching, and peer-to-peer exchange.

LOOKING FORWARD

Teams reflected that after RBN, approaches that had been (or could be) institutionalized into organizational practice or culture seemed more likely to sustain (e.g., ACEs screening, TRIS training) and some reported mindset shifts that are part of how they now do their work. RBN produced a cohort of leaders, champions, and advocates for TRIC who are committed to continuing their journeys to have more healing cultures of care within their organizations.

> **IDEAL STATE: TRAUMA- AND RESILIENCE-INFORMED MODELS OF PEDIATRIC PRIMARY CARE**
>
> RBN teams' vision for trauma- and resilience-informed pediatric care were relatively consistent and centers on three elements:
>
> - **Patient care** that builds connection among patients, families, and the care team, is strengths-based and holistic, and situates the patient as "expert."
>
> - **Support for staff** that embeds approaches to mitigate secondary or vicarious trauma and builds a team-based culture.
>
> - **A physical clinic environment** that is child-centered, physically accessible, and reflects the cultural diversity of the communities they serve.

CONSIDERATIONS

Based on teams' progress during RBN, along with reflections by program partners and CCHE's experience evaluating other similar initiatives, the evaluation team offers six considerations for ongoing or future investments in trauma- and resilience-informed care initiatives.

1. Given the various entry points to advancing trauma- and resilience-informed care, **funders and program implementers need to determine the goal(s) of an investment and design and fund the program in accordance with the goal**. This requires weighing trade-offs in determining the breadth and depth of this type of program, making decisions about which program elements to include, and appropriately messaging and managing expectations.

2. **Staff training on trauma- and resilience-informed systems that includes time for discussion and reflection along with content, is necessary and a critical foundation for doing this work.** Training establishes collective understanding and shared language of trauma- and resilience-informed cultures of care. It builds important relationships and fosters buy-in and momentum for the work that follows. All of this is important groundwork for various other aspects of trauma- and resilience-informed care.

3. **When ACEs screening is implemented alongside broader TRIC concepts, both care teams and patients are more supported, and it ensures screening is helpful versus harmful.** Screening is most beneficial when it is part of relational, coordinated, and holistic/whole-person care practices. Effectively screening requires foundational work and supportive structures beyond the technical aspects of administering the screen.

4. **Programs focused on TRIC must intentionally include goals and resources related to supporting staff and provider wellbeing—this was a unique value add of RBN, addressing a needed gap but very challenging given the culture of the safety net.** Doing trauma- and resilience-informed care and equity and racial justice work in a health care context can be emotional and taxing, so stepping back to regularly and systematically "care for the carers" is needed to sustain and advance the work.

5. **The RBN themes of Equity and Racial Justice, Strengths-Based Approaches, and Patient and Family Engagement took more time and support to understand, digest, and operationalize than clinical processes such as ACEs screening.** The evaluation largely found that transformation in these areas centered on teams shifting their thinking from the what to the how of providing care and required embodying or holding this orientation in all aspects of teams' work. Programs that incorporate or focus on these more complex topics will likely need to be on a longer timeframe to see concrete progress or action.

6. **Advancing TRIC is complex, long-term, culture change work that benefits from the work of a stable, multi-disciplinary team with effective leadership, the ability to articulate a clear and realistic scope, and engagement of and access to people who can authorize and meaningfully support its implementation (i.e., organizational leaders and decision makers).** Supporting these facilitators and mitigating key barriers (time, competing priorities, workforce issues) is critical for program success. RBN did this through multi-pronged support such as individualized coaching and technical assistance and complementary program requirements.

Resilient Beginnings Network:
Final evaluation report
February 2024

A growing awareness around the impact of trauma on people's health and wellbeing has underscored the need for trauma-informed and strengths-based approaches in working with patients and communities. Resilient Beginnings Network (RBN) was a three-year learning program dedicated to advancing pediatric care delivery models that are trauma- and resilience-informed so that 100,000 young children and their caregivers have the support they need to be well and thrive.

RBN launched in November 2020, led by the Center for Care Innovations (CCI) with funding support from Genentech Charitable Giving. RBN expanded on an earlier two-year partnership between CCI and Genentech called Resilient Beginnings Collaborative (RBC) with similar goals that engaged seven organizations. RBN supported 15 safety net organizations in the San Francisco Bay Area of California, five of which participated in RBC (see RBN teams section below). had a strong pediatric focus, were committed to trauma- and resilience-informed care (TRIC), had interest in applying an equity and racial justice, and were willing to both teach and learn from their peers over the three years.

> **Trauma- and resilience-informed care** refers to care in which all parties involved recognize and respond to the impact of traumatic stress and resiliency factors on children, caregivers, and service providers.
>
> (adapted from **SAMHSA**)

RBN took a holistic and integrated approach to TRIC, including centering dignity and equity as a core component of all aspects of the program and its work. This holistic approach was grounded in education from Vital Village Networks on the Dignity Framework, which explains how equity, dignity, childhood adversity, and structural racism are intertwined. RBN structured potential TRIC organizational or clinical practice changes into four domains. These domains provided teams potential entry points to the work.

Organizational environment	Prevention & promotion	Clinical practices	Community partnerships
Establishing or deepening a trauma-informed and healing-centered clinic and organizational environment, including improved support for staff wellbeing	Promoting resilience and protective factors among young children and their families that can lower the risk of developing physical and mental illnesses linked to adverse childhood experiences (ACEs)	Testing, implementing, and spreading clinical practices to prevent, identify, respond to, and heal trauma and early childhood adversity	Building and strengthening community relationships so that referrals and coordination efforts meet community, patient, and family needs

RBN also promoted changes in three cross-cutting themes affecting how teams conduct TRIC work in every domain: equity and racial justice, strengths-based approaches, and patient and family engagement.

The four domains and three cross-cutting themes provided clear areas of work for teams to engage with during the program. At the beginning of the program, teams likely recognized each of these areas as connected and important. But given the breadth of TRIC implementation, teams were encouraged to focus their RBN efforts on a few strategies they deemed salient and build momentum from there. Teams were not required to have goals related to or conduct work in all domains during the program. Therefore, findings in this report are often presented as distinct areas of work, although it was commonly understood these were pieces within a larger umbrella of TRIC.

The RBN domains and cross-cutting themes were aligned with other frameworks of TRIC and practices such as the [Pediatric Integrated Care Collaborative](#) (PICC) Change Framework and the Center for Health Care Strategies' [Key Ingredients for Successful Trauma-Informed Care Implementation](#) and are inclusive of all the various aspects commonly associated with this work (e.g., office environment, assessing and addressing trauma-related health problems, promoting resilience, clinical and non-clinical staff training, patient engagement, preventing secondary traumatic stress in staff). CCI used these existing frameworks as a starting point to build a digestible program structure for participating teams to engage with over the three program years. RBN provided various entry points to TRIC, reinforcing their interconnectedness and presenting this work as a long-term effort to shift mindsets, practice, and culture within health care organizations. The program was designed to address the ways health care organizations can be "trauma organized" meaning they are impacted by stress, are hierarchical, fragmented or operate in silos, and isolated in their practice or service delivery.[1] Promoting TRIC within health care requires new ways of working and disrupting existing practice. The program also emphasized and promoted leadership engagement and support as a necessary element to advance TRIC given the need for broader organizational culture change.

RBN PROGRAM ELEMENTS

Participating teams received:

- A range of training & technical assistance (e.g., virtual learning, individualized coaching, access to subject matter experts and resources)
- Structures for peer learning (e.g., communities of practice sessions at learning sessions)
- Site visits to organizations implementing trauma- and resilience-informed care
- $120,000 in grant funding

For the majority of the program, RBN activities were limited to virtual events and touchpoints due to the COVID-19 pandemic—a shift from CCI's typical learning collaborative* approaches. CCI held a final in-person convening for all participants in September of 2023.

*A learning collaborative is a method for supporting practice change in which teams of peers and recognized experts come together to learn from each other and apply quality improvement methods in a focused topic area (e.g., trauma- and resilience-informed care).

RBN was also influenced by several external, contextual factors. The program coincided with the outbreak of the COVID-19 pandemic, a national racial justice reckoning in response to the murder of George Floyd, increasing levels of hate focused on the Asian population, and growing divisions in the country following the violent riot in Washington, DC on anuary 6, 2021. These events, along with climate catastrophes including floods and fires, strained an already overly stressed health care system. During RBN, health care organizations experienced unprecedented challenges responding to increasing and ever-changing demands, including workforce attrition and shortages. The remaining primary care teams were asked to increase their workload, often with limited training and support.

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[1] [Trauma-Informed Systems Model.](#)Trauma Transformed.

Evolutions in the field of TRIC also influenced RBN. About a year prior to RBN's launch, the State of California launched its ACEs Aware Initiative, which included reimbursement for ACEs screening for Medi-Cal (California's Medicaid program) enrollees, along with other supportive training and resources for ACEs screening and response. ACEs Aware invested significant funding, training, and technical assistance for ACEs screening and response efforts including supports for trauma- and resilience-informed care more broadly. This included acknowledging the intersections of ACEs and racial (in)justice, elevating the importance of identifying strengths and protective factors, building resiliency, and prompting community partnerships to more holistically care for patients and families.[2, 3] During this time of collective trauma and change, RBN aimed to meet each team where they were on their organizational journeys to becoming trauma- and resilience-informed, within the larger environmental pressures and opportunities for health care organizations.

RBN TEAMS

RBN engaged 15 safety net organizations serving eight counties across the Bay Area. While all 15 were Federally Qualified Health Centers (FQHCs), there was wide variation in their organizational context. Ten of the RBN teams were at community health centers that varied in size from two to 22 clinic sites. Four teams were part of large, public health systems, three of which were based out of pediatric clinics within public hospital settings. One team was at an organization that operates several school-based health centers. The number of pediatric patients aged 0-5 years served annually by RBN teams' organizations ranged from around 230 to over 17,000.

RBN teams came from organizations with different types and levels of experience with TRIC. Five organizations participated in RBC, RBN's precursor program, though change in participating clinic sites and/or individual team members was common. Prior to RBN, six teams' organizations had engaged in

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[2] Case Study: California's ACEs Aware Initiative - National Governors Association (nga.org)
[3] Roadmap for Resilience: The California Surgeon General's Report on Adverse Childhood Experiences, Toxic Stress, and Health

initiatives or research focused specifically on ACEs screening and response. During RBN, six teams' organizations also received grant funding from the ACEs Aware Initiative related to specific technical assistance areas (see above) to advance different components of ACEs screening and response.

See Appendix A for a more detailed overview of RBN teams and organizations.

Alameda County	Sonoma County	Alameda & Santa Clara Counties	San Francisco County	Solano County
Alameda Health System	Alliance Medical Center	Bay Area Community Health	Children's Health Center Zuckerberg San Francisco General Hospital	Community Medical Centers
Alameda & Contra Costa Counties	Marin County	Marin County	San Francisco, San Mateo & Santa Clara Counties	Marin & Sonoma Counties
LifeLong Medical Care	Marin City Health and Wellness Center	Marin Community Clinics	North East Medical Services	Petaluma Health Center
San Francisco County	San Mateo County	Sonoma County	Santa Clara County	Alameda County
South of Market Health Center	San Mateo County Health	Santa Rosa Community Health Centers	School Health Clinics of Santa Clara County	UCSF Benioff Children's Hospital Oakland

WHAT ARE KEY ELEMENTS OF THE RBN EVALUATION?

The Center for Community Health and Evaluation (CCHE) conducted the RBN evaluation, which aimed **to promote learning** by documenting teams' promising practices and lessons learned, including facilitators and barriers to implementing TRIC practices and approaches. The evaluation was organized around the four RBN program domains and three cross-cutting themes. This includes evaluation activities to:

- **Assess changes in organizations' capacity** in implementing trauma- and resilience-informed pediatric care practices and approaches.

- **Understand and track progress** in RBN program domains and cross-cutting themes.

- **Capture stories or examples** of advancements in healing-centered pediatric care models.

- **Understand the contribution of the RBN program** to organizations' progress, including assessing the relative value of different program components.

To achieve these goals, the evaluation developed a program logic model and used mixed methods to collect and analyze data. The table below outlines each data collection method, and more information about data collection and analysis processes can be found in Appendix B. This report includes results from data collection activities during all three years of RBN (November 2020 – October 2023). After each data source was analyzed, the evaluation team looked at results across methods to triangulate data and develop the key findings presented in this report. While some key findings rely more heavily on a single data source, all were derived from a mixed-methods, thematic analysis.

Data collection activity	Description
Organizational capacity assessment	An assessment of organizational practices and capacities related to TRIC including multiple items for each RBN program domain and cross-cutting theme. Each RBN team collaboratively completed the assessment resulting in one response for each RBN organization. Teams completed the assessment three times—baseline in January 2021, midpoint in May 2022 and final in August 2023.
Team interviews	One-hour interviews with each RBN team to gather their reflections on RBN work underway, success factors and challenges, and feedback on the RBN program. Completed annually with all 15 teams in 2021, 2022, and 2023.
Participant survey	A web-based survey administered to all active RBN participants to assess progress towards RBN outcomes, key success factors and challenges, and participant experience engaging in RBN. Administered annually in late 2021, 2022, and 2023.
Document review	Review and analysis of RBN program assignments and reports including applications, team storyboards and roadmaps, and quarterly reflections.
Reflections from RBN faculty	Facilitated discussions with RBN coaches, subject matter experts, and program staff to reflect on evaluation findings and gather additional insight about RBN teams' work.
Observation of program events	Participation in and observation of RBN program events including virtual learning sessions (including community of practice discussions), webinars, pitch and commit events and the final in-person convening.

EVALUATION FINDINGS

Six key findings from the evaluation are presented in two sections:

- What Happened: Key findings on outcomes from RBN

- What It Takes: Key findings on learnings from RBN

Additional information on sustainability and RBN teams' reflections on ideal state for TRIC in pediatric primary care settings follow the key findings.

WHAT HAPPENED –
KEY FINDINGS ON OUTCOMES FROM RBN

1

ACEs screening continues to be a concrete entry point for teams seeking to advance trauma- and-resilience-informed pediatric care and is more effective when situated alongside other foundational efforts that support administration and response.

ACEs screening was the most common intervention that gained traction within RBN due to the tangible nature of the strategy and the supportive policy environment for ACEs screening in California. A state policy change prior to RBN provided reimbursement for ACEs screening for patients enrolled in Medi-Cal (California's Medicaid program). As a result, the state funded training and other resources that prompted safety net organizations across the state to prioritize ACEs screening implementation. Nearly all teams started RBN with either ACEs screening efforts underway or as a primary goal for the program. It was the one strategy where all teams who prioritized it reported at least *moderate progress.*

By the end of the program, 11 teams demonstrated progress related to ACEs screening.[4] Seven of those were either new to screening or implementing screening at new clinic sites. Capacity assessment results showed ten RBN teams improved pediatric ACEs screening practices between 2021 and 2023; the cohort's average increased from 2.5 to 3.9 (above *variable/ moderate* capacity on a 5-point scale). In 2023, seven teams rated their organization the maximum of 5, indicating that pediatric ACEs screening practices were fully and consistently in place. Additionally, teams reported notable improvement in three aspects of the process related to ACEs screening (see Figure 1).
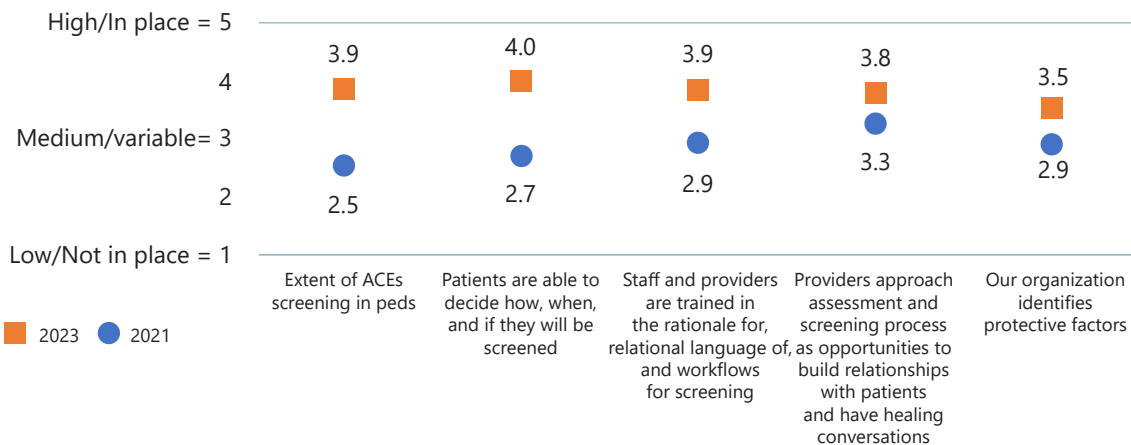
> **WHAT ARE ACES?** Adverse Childhood Experiences, or ACEs, are potentially traumatic events that occur in childhood (0-17 years). ACEs can have tremendous impact on future violence victimization and perpetration, and lifelong health and opportunity. (CDC)
>
> **WHAT IS ACES SCREENING?** ACEs screening is a clinical questionnaire and assessment process to rapidly identify patients at highest risk for toxic stress and perform the next steps of a more complete, individualized assessment for each of them. A complete ACEs screening involves assessing:
> - Adversity (the ACE score)
> - Clinical manifestations of toxic stress (ACE-associated health conditions)
> - Protective factors
>
> (ACEs Aware)

Figure 1: Capacity assessment items related to ACEs screening, 2021 & 2023

	Extent of ACEs screening in peds	Patients are able to decide how, when, and if they will be screened	Staff and providers are trained in the rationale for, relational language of, and workflows for screening	Providers approach assessment and screening process as opportunities to build relationships with patients and have healing conversations	Our organization identifies protective factors
2023	3.9	4.0	3.9	3.8	3.5
2021	2.5	2.7	2.9	3.3	2.9

High/In place = 5
Medium/variable= 3
Low/Not in place = 1

⬛ 2023 🔵 2021

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[4] One team had fully and systematically implemented ACEs screening prior to RBN through participation in other CCI programs (Resilient Beginnings Collaborative and California ACEs Learning and Quality Improvement Collaborative (CALQIC)), so it was not a priority for them during RBN.

Teams focused their ACEs screening efforts on various phases of the process: laying the foundation, implementing workflows, and response and follow-up. Evaluation of other CCI programs has documented promising practices related to ACEs screening implementation[5] and the Resilient Beginnings: Trauma-and-resilience-informed ACEs screening and response learning brief provides additional information about the focus of screening implementation efforts within RBN.

RBN was unique from other ACEs screening programs in that it was situated within a larger context of trauma- and resilience-informed organizational cultures of care, which generally helped to strengthen screening practices. This broader frame influenced how some RBN teams approached ACEs screening and response and their perceptions of the value and importance of screening activities. The following outcomes are largely due to screening efforts occurring within the context of RBN:

- **An increased focus on the process (the *how*) of screening and response:** In general, RBN teams saw screening as one important component in a larger effort to become healing organizations. As a result, teams reported shifting their mindset to think about how they are screening, beyond only tracking whether screening occurred. This included intentionally integrating approaches and practices that supported the patient, family, and staff involved in the process. This helped ensure that screening was helpful and not harmful and brought beneficial outcomes for staff, patients, and families. RBN teams overall saw value in ACEs screening, believing that it was a helpful tool to gather important information about their patients, introduce education and resources, have deeper conversations, and build relationships and trust.

> *"[ACEs screening] is the most important stuff we do, I believe, but it really is both time and emotionally taxing. You've got to give respectful space and quiet around something so heavy."*

- **Integration of strengths-based approaches and resilience messages:** Seven teams conducting ACEs screening reported that explicit discussion of patient and family strengths and resiliency messages were intentionally part of the screening process, though mostly through informal processes. Five teams commented that ACEs screening has given providers opportunities to shift their thinking to point out the family strengths, reorienting from "What are you going to stop doing?" to "What do you like to do already that benefits your health?"

- **More holistic care:** Teams reported that this approach to screening helped improve care delivery by working with patients and families more holistically. Teams reflected on how the process of ACEs screening, including the related in-visit discussions, helped them shift their mindset to see patients and families with more empathy, as whole people, and better address relevant needs. One RBN participant reflected that trauma and resilience, along with associated practices and approaches, were not concepts that pediatricians have historically focused on in their training and that RBN's approach equipped them with that needed language and framing.

- **Elevating and reinforcing the importance of foundational organizational work related to TRIC** so that it is the backdrop for screening: Several teams discussed the importance of strengthening organizational environments to be more trauma- and resilience-informed prior to implementing ACEs screening so they are more supportive of both patients and staff. Two teams began RBN with a primary goal of starting ACEs screening and decided to pause, step back, and first conduct general trauma- and resilience-informed systems training for all staff. Two other teams discussed creating safe and trusting environments and training their providers in leading empathetic conversations with

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[5] See Screening for adverse childhood experiences (ACEs) in pediatric practices or the California ACEs Learning and Quality Improvement Collaborative evaluation results for more information.

patients. These activities helped to fill knowledge and training gaps and helped build buy-in among provides and staff.

- **Intentional efforts to engage staff in developing screening practices (e.g., workflows, scripts) and provide ongoing training and support:** Two teams commented that it was helpful to engage multi-disciplinary staff members in planning workflows so that the people expected to perform the screening provide input on how to ensure its success. Other teams highlighted the usefulness of providing opportunities for staff to personally connect with the screening content prior to implementing with patients and families. A couple of RBN teams also described peer support structures to help provide training, support, and coaching to care teams during implementation.

- **Improvements in referral relationships and practices:** While most teams started RBN with an ability to connect families to community supports, several teams continued to seek out new partnerships, develop relationships, and establish systems for referral and follow-up. For some teams this was connected to ACEs screening implementation and wanting to ensure they could address patient and family needs. Others aimed to expand the general types and levels of service they provided. Through this work, six teams reported an increase in the extent to which their organizations have established practices to follow up and close the loop on patient referrals to community resources and described improved collaboration and relationships. This work also helped to address a key concern providers had related to screening: "opening a can of worms" and not knowing what to do or not having strong referral systems when patients need additional support.

- **Integration of a case manager or care coordinator position to support the screening process:** Three teams discussed the importance of having a dedicated position to help ensure both staff and patients have the support they need at all phases of the screening process. Teams perceived screening went more smoothly and was more effective at sites where these roles were in place. These roles:

  ◊ Helped explain or administer the screening to patients
  ◊ Provided additional resources for staff during the screening process
  ◊ Were a warm handoff for providers when patients and families needed additional services or support
  ◊ Identified and provided connection to community resources and services
  ◊ Built relationships with patients and community-based organizations
  ◊ Managed follow-up communication with patients and partners to close the loop
  ◊ Assuaged provider concerns that they would not be able to address patient and family needs that emerged from screening

> *"As the care coordinator we built a little community on behalf of ACEs with the receptionist, medical assistant, provider and supervisors. Once they know that we're here to support them and make everything as smooth as possible they don't feel so overwhelmed."*

See CCI's feature articles on two RBN teams testing this strategy for more information: [How One California Clinic Tapped a Bilingual Medical Assistant to Lead ACEs Work](#) and [Pediatric Care Coordinators: Closing the Loop to Help Children at Risk Thrive](#).

Overall, **RBN teams felt patients to be receptive to screening processes**, even when they did not disclose adverse experiences the first time they completed the questionnaire. Teams reported that interactions with patients and families were positive overall, that patients appeared comfortable

with trauma-related conversations, and that the process generally promoted trust. That said, teams also reported challenges related to patient and families' roles in the screening process. This included: reluctance to completing the questionnaire/forms (due to time, remembering, willingness, perceptions of too many questions), honestly answering the screening questions, and accepting or following through on recommended supports following a positive screen. As discussed above, the case manager or care coordinator position helped support patients in the process, including following up with patients after the screen.

Other primary challenges were consistent with general ACEs screening efforts and are discussed in detail in the Resilient Beginnings: Trauma-and-resilience-informed ACEs screening and response learning brief.

At the end of the program, nine teams were optimistic that their screening efforts would sustain and expand after RBN was over suggesting that most teams were able to embed ACEs screening and response into standard pediatric practice for at least a subset of their pediatric providers. A few teams shared that they were less confident in how to sustain the training of staff involved in the screening workflow. As one team lead shared, *"My biggest fear is that if I leave tomorrow all this knowledge leaves with me. The organization doesn't build structures to support documentation of processes we build. So, I am focused on setting up formalized training and documenting everything that supports the screening process."*

💡 BRIGHT SPOT: CASE MANAGER SUPPORT IN ACES SCREENING

Bay Area Community Health Center (BACH) is a large community health center with 34 sites across two counties. BACH worked to implement ACEs screening for about four years prior to RBN and focused on expansion and refinement of their workflows and referral processes when they entered RBN. The team was clear that they wanted to do more than simply identify vulnerable children who need interventions and assistance. They also wanted to support them by closing the loop through referrals and warm handoffs to specialist providers, including behavioral health practitioners.

The pediatric care coordinator role has made a "tremendous" impact on their ACEs screening workflow in BACH's Fremont clinics. This role was launched as part of another grant in January of 2021, and it quickly became clear that they could assist with both the rise in pediatric patients diagnosed with autism and had not received treatment during the beginning of the pandemic, as well as patients who have multiple social needs. The pediatric care coordinator engages providers and staff and supports the workflow by:

- Monitoring referrals in the electronic health record where referral status is tracked.
- Dedicating time to reach out and establish relationships with community-based organizations to clarify referral possibilities.

BACH's IT department built "smart touch" forms to help track the pediatric care coordinator's work to help make the case for future funding for the position. The role was so successful that it extended beyond the initial pilot period and BACH is interested in expanding the model to other clinic sites.

2

RBN elevated staff and provider wellbeing as a key tenant of TRIC and most RBN teams engaged in a variety of activities to strengthen organizational practices supporting staff and providers during a time of immense stress on the health care system. Scope and frequency of these efforts varied.

Supporting staff and provider wellbeing was a unique and important aspect of RBN. While in general these efforts were not articulated goals in teams' program proposals, **RBN prompted recognition of the importance of this work by explicitly shining a light on the people providing care and modeling reflective and wellness practices**. Several RBN teams commented on their "shift" to take care of the care team beyond only thinking about patients' needs and interests and identified this as an important lesson resulting from RBN. Since RBN began in late 2020, this was particularly applicable in the context of COVID-19 exacerbating stresses on the health care system contributing to workforce burnout and staffing challenges (e.g., turnover, shortages). Five teams reported cultural challenges within health care systems that prioritize patient access and put too much on employees' plates paired with insufficient time. These pressures affected individuals, teams, and organizations participating in RBN and they articulated these workforce issues as a persistent challenge throughout the program.

> *"I would say you've got to start with your caregivers, resource your caregivers. Because if you want them to be able to pour into your patients you've got to pour into them first."*

Most (11) RBN teams reported working on staff and provider wellness, and 75% of survey respondents reported *Moderate* and *Significant* progress in this area in 2023. Efforts included:

- **Bringing staff together** in different ways, both within and beyond the clinic. This allowed staff to build empathy for one another by getting to know each other and shift their mindset to see each other as people beyond their professional roles. This included starting regular all-staff meetings, having an all-staff "wellness retreat" (i.e., a picnic) at a local park, convening a peer support group for Spanish speaking clinicians, interviewing staff and sharing their stories internally, and creating reflective, debrief spaces to support intensive clinical activities like ACEs screening.

- **Making wellness services or activities available** to staff (e.g., adding mindfulness practices to meetings, integrating Moments of HOPE into staff meetings and activities, providing brief acupuncture or yoga sessions).

- Making the **clinic space more welcoming and supportive** for staff including creating a community board, hanging signs with positive messaging, establishing No Hit Zones and adding greenery to the clinic.

- **Collecting feedback on staff experience.** This included administering staff surveys and working with a consultant to do staff journey mapping. Soliciting formal feedback from all staff and providers on compassion fatigue, secondary

💡 BRIGHT SPOT: STAFF RETREAT AT ALAMEDA HEALTH SYSTEM

The pediatric department of Alameda Health System's Highland Hospital hosted two "staff wellness retreats" at a nearby park for clinic staff and their families. They indicated it was a positive experience to interact with and get to know colleagues in a more informal and personal way, away from the stress of the clinic. Retreats consisted of a hike and lunch and attendees received "wellness bags." The RBN team received positive feedback and thought the event strengthened relationships in a way that supports people to more easily collaborate and communicate at work. The team lead said was a particularly positive experience coming out of the COVID-19 pandemic; they *"got to see each other without masks, without socially distancing, and without the stress of the clinic setting."*

More information about this work is available in CCI's feature story.

traumatic stress, and burnout was an item where teams reported notable growth on the capacity assessment (the average score increased from 1.93 in 2021 to 3.07 in 2023). One team that conducted a more robust staff assessment process presented findings to leadership with recommendations; leadership committed to some of the improvements suggested (e.g., improving clinical and waiting room spaces).

- One team made staff wellbeing a **formal clinic quality improvement (QI) priority** so they could use QI funds to support team building activities like an all-staff retreat.

While teams engaged in a variety of different activities, broader organizational impacts like reports of culture change as a result of centering staff wellness and changes in the capacity assessment were variable and slower to come. Teams reported hearing informal positive response to efforts to support staff and providers and observed strengthened interpersonal relationships within their clinics.

However, some wondered about, and noted challenges assessing, if they were making a substantive difference on staff morale and engagement. Capacity assessment results in 2023 continued to see improvement but change was slower than other program areas. This section increased by 0.57 from 2021 to 2023 and was consistently one of the lowest rated sections during RBN (the lowest rated at 3.14 or *medium/variable* in 2023). Additionally, while eight teams reported improvement of at least 1.0 in their average rating, three reported decreases of 1.0. The remaining four teams reported less change.

Teams reported **ongoing challenges carving out time to do this work** particularly given competing priorities and the broader culture of health care (i.e., the primacy of patient care in a fee for service environment and expectations that providers and staff take on more and more). *Having a dedicated position to lead and support staff wellbeing work* was consistently one of the lowest rated items in the capacity assessment (2.43 in 2023) and did not show change during the program. Qualitative data indicated that RBN team members often took the lead on establishing or facilitating these efforts, suggesting that it was extra work in addition to other priorities.

Additionally, some teams reported encountering resistance when trying to integrate reflection or carve out reflective spaces in such a reactive and responsive environment. The multi-disciplinary RBN team was cited by some teams as an effective space for debrief and reflection, getting to know each other personally, and peer support. Individually, there was consistently mixed agreement among RBN team members in the participant survey on whether they personally regularly practice self-care (taking care of their own needs and wellbeing), with just 39% *strongly agreeing* and 48% *somewhat agreeing* in 2023 (see Figure 2).

Figure 2: I regularly practice self-care (taking care of my own needs and wellbeing), 2023 (n=44)

I regularly practice self-care (taking care of my own needs and wellingbeing).

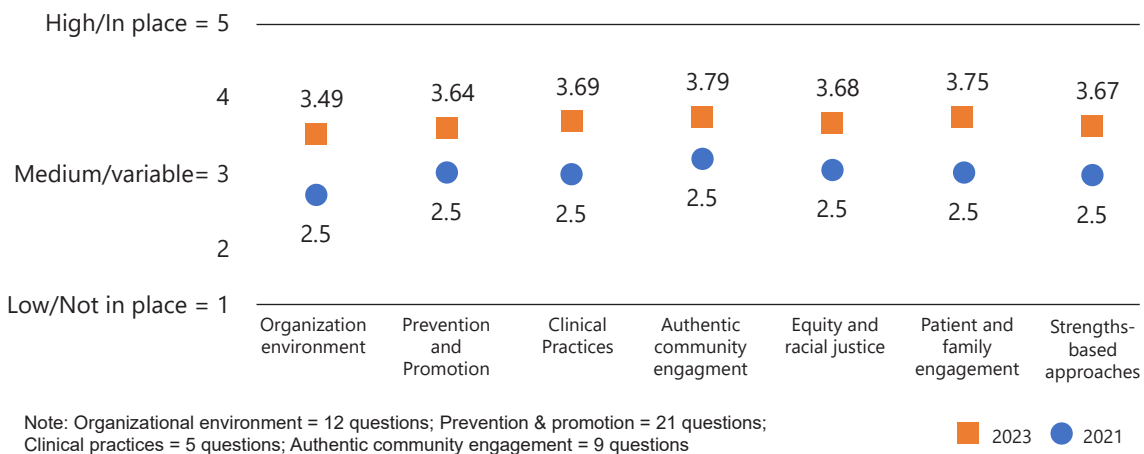■ Strongly disagree　■ Somewhat disagree　■ Somewhat agree　■ Strongly agree
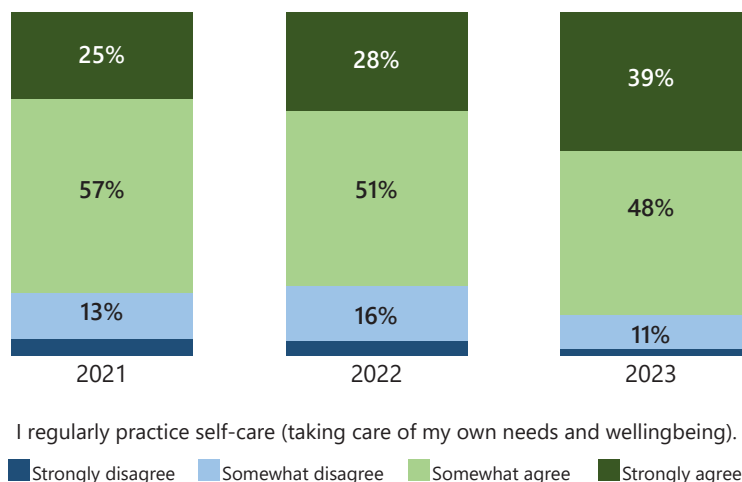
Staff wellness work that was more embedded into organizational systems and processes like all-staff meetings, promoting Employee Assistance Programs, or clinic environment changes like wellness spaces seemed more likely to continue beyond RBN. Teams generally considered staff support an ongoing need and priority, but some had questions about how they will continue aspects of this work without the funding, dedicated time, and team provided by RBN.

3 In addition to sustainable progress in discrete TRIC strategies, RBN began to shift broader clinic culture to be more trauma- and resilience-informed.

Each RBN team developed unique goals and strategies to advance trauma- and resilience-informed approaches that aligned with their organizational context. Beyond these specific strategies, **RBN provided opportunity for organizations to grow in every aspect of being trauma- and resilience-informed**. This speaks to the broader influence of RBN concepts and practices beyond the individual strategies teams worked on, signaling the beginnings of wider shifts to clinic culture. In the RBN organizational capacity assessment, average ratings of all program domains and cross-cutting themes increased from the beginning of RBN (between 0.63 and 0.77 on a 1 to 5-point scale). These increases pushed each domain and cross-cutting theme to a rating of 3.5 or above, indicating that these capacities and practices were in place above a *medium/variable* level. This was different from what happened during CCI's first Resilient Beginnings cohort that ended in 2020, where some domains saw substantively larger increases than others, and some no change at all.

Figure 3: Program drivers/domains and cross-cutting themes average score, 2021 & 2023

Note: Organizational environment = 12 questions; Prevention & promotion = 21 questions; Clinical practices = 5 questions; Authentic community engagement = 9 questions
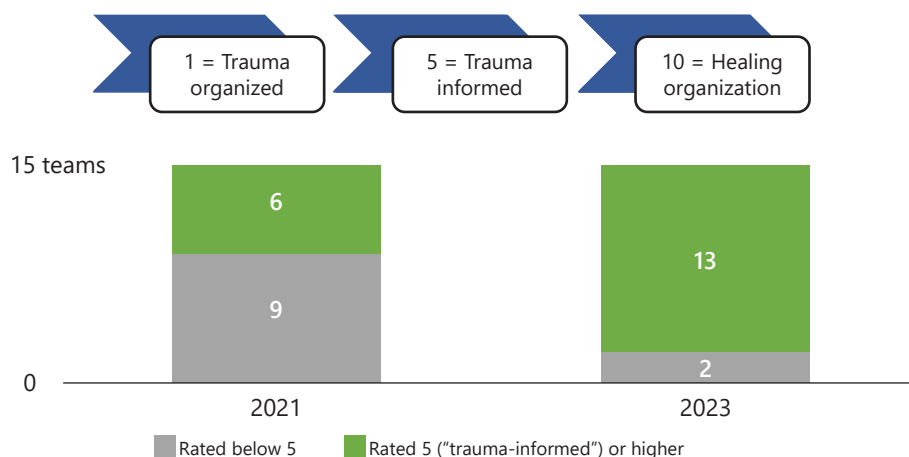
RBN's broader frame of TRIC prompted teams to consider and be intentional about how their program work (e.g., staff training, ACEs screening) contributes to healing cultures of care. Though there was variation in where **teams started RBN and how they brought TRIC approaches into their work, teams overall perceived their organizations to be progressing in their journeys to become healing organizations**. Trauma Transformed defines a healing organization as one that reduces trauma by being reflective, makes meaning out of the past, is growth and prevention oriented, is collaborative, values equity and accountability, and has relational leadership.[6] The RBN capacity assessment asked teams to rate their organizations on a scale between 1 (trauma organized) to 10 (healing organization).[7] From 2021 to 2023, 13 teams improved by at least one rating and six teams progressed by three or more. Nearly all teams rated themselves at level five or above in 2023, compared to less than half in 2021 (see Figure 4).

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[6] Trauma Transformed: 8.5x11_Healing Organization Chart (traumatransformed.org).

[7] While the evaluation asked for consistency in the team members who responded to this capacity assessment, this wasn't always possible due to turnover in the team. Some variation in ratings is likely due to inconsistent perspectives of team members as they shifted over the three-year program.

Figure 4: RBN teams' healing organization score, 2021 & 2023

| 1 = Trauma organized | 5 = Trauma informed | 10 = Healing organization |

15 teams

2021: 6 (green), 9 (grey)
2023: 13 (green), 2 (grey)

0

☐ Rated below 5   ☐ Rated 5 ("trauma-informed") or higher

Among the four RBN domains, *Organizational Environment* had the largest increase during the RBN program (0.77 on a 1 to 5-point scale). This domain includes a group of six questions related to *Organizational culture and commitment to TIC*[8] and *equitable practices*. These questions reflect areas where teams noticed organizational culture shifts, including placing value on non-clinical staff members' experiences and expertise, having policies and procedures that support healing, and providing training and support to address personal biases and microaggressions. This group of questions was one of the highest rated on the entire assessment in 2023 (3.80, see Figure 5).

Figure 5: Capacity assessment items from *Organizational culture and commitment to TIC and equitable practices section, 2021-2023*

Item	2021 avg.	2023 avg.	Change
Non-clinical staff members' unique expertise and lived experience is acknowledged as valuable to the care of our patients and families	2.87	3.86	0.99
Role of organizational policies and procedures in healing trauma and supporting equity and cultural humility	2.67	3.60	0.93
Organization provides training and support to address implicit and personal biases, microaggressions, etc. among staff and in patient care	2.80	3.60	0.80
Leadership buy-in and commitment to equity and trauma and resilience-informed care	3.21	3.80	0.59
Organization reflects the racial, ethnic, and cultural diversity of our patient population	3.40	3.93	0.53
Different cultural norms of staff members are valued, and employees do not have to assimilate or leave a part of themselves behind when they come into the workplace	3.64	4.08	0.43

[8] Trauma-informed care

Eight teams shared other examples of broader culture change resulting from RBN, including those who explicitly mentioned the term "culture change" and increased awareness of the interpersonal and organizational healing work that needs attention in their clinics. These examples included:

- Building a common language and perspective on trauma- and resilience-informed systems and care.
- Changing how people work with each other and with patients such as framing patient care around strengths and developing self-awareness and vulnerability with teammates.
- Reorienting to new ways of thinking based on concepts presented in the trauma- and resilience-informed systems (TRIS) training ("supporting reflection in place of reaction, curiosity in lieu of numbing, self-care instead of self-sacrifice and collective impact rather than silo-ed structures") and the Dignity Framework ("understanding how attention to dignity can help to strengthen relationships, resolve conflicts, and make organizations more successful").

The remainder of this section discusses two key RBN strategies that contributed to these changes in organizational culture:

- **Training and education.** Education and training activities exposed participants to new concepts, raising awareness and understanding of trauma- and resilience-informed approaches, and often reached clinic team members who were not participating in RBN.
- **Engagement and voice.** Efforts to elevate the voices of patients, families, and community partners, which allowed the experiences and desires of people outside the clinic walls to influence what happens within them.

Training and education

RBN participants increased their understanding of trauma- and resilience- informed cultures of care and practice. In each year of RBN, survey respondents grew in *Strong agreement* that they have a comprehensive understanding of these concepts, from 41% in 2021, to 51% in 2022, and 66% in 2023 (overall agreement was more than 95% all years, see Figure 6). This statistically significant increase aligns with participants reporting that increasing knowledge and confidence was a key priority of their work: 93% reported *Moderate* and *Significant* progress in the last two years of the project (86% reported similar progress in 2021).

> *"I was someone who had previously taught about trauma informed care, but RBN has deepened my understanding of what that can look like and has provided tools that I can now use to spread this teaching beyond what I was doing previously and actually take steps towards changing our broader clinic system/ culture."*

Figure 6: Understanding of trauma- and resilience-informed cultures of care, 2021-2023

I have a comprehensive understanding of trauma- and resilience-informed cultures of care and practice.
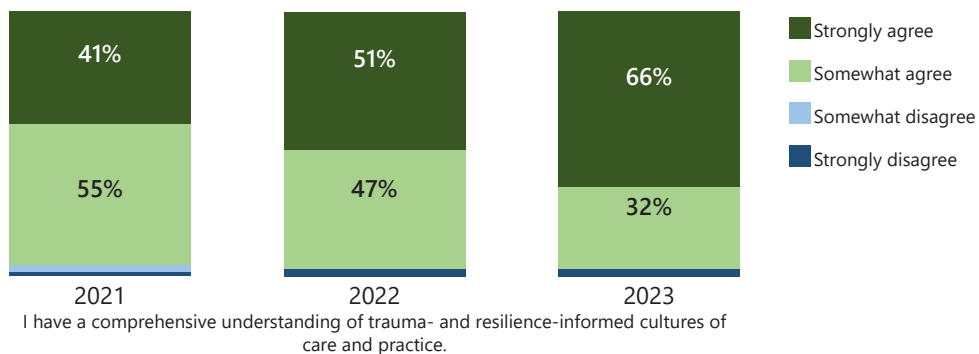
Training was the most common strategy for increasing awareness and understanding to help advance TRIC. Eleven teams engaged in some type of training, especially in the first year of RBN. Training topics varied, including: trauma and resilience-informed systems (TRIS) generally, ACEs screening implementation, resilience, motivational interviewing, empathy, de-escalation, the HOPE framework, Healthy Steps, and diversity, equity, and inclusion.

Six RBN teams opted-in to TRIS training provided through RBN in partnership with Trauma Transformed. These teams typically piloted the TRIS training video modules with their RBN team before expanding to different groups in their clinic/organization. Two teams observed that the training established shared understanding and common language among participants and reported seeing differences in how staff were interacting both with each other and with patients. Another team highlighted the importance of the trainings in bringing staff together to share and build connection with one another. They perceived genuine commitment to put learning into practice. The primary challenge with TRIS training implementation was logistical—the time it took provide, as well as time to continue to engage with the content. Teams tried to build in time to continue to revisit and reinforce concepts from the training. Two teams mentioned building out their onboarding processes to include training and materials on TRIS. See CCHE's TRIS Training Topical Learning Brief for more detail.

> **Trauma- and resilience-informed systems (TRIS)** training was the most common general training conducted by RBN teams. TRIS is inclusive of, but broader than trauma- and resilience-informed care (TRIC). In this report, TRIS refers to a specific training curriculum and process provided in partnership with Trauma Transformed.

Patient, family, and community voice

RBN teams also encouraged culture change by elevating patient, family, and community voice, signaling a shift from more top-down approaches commonly practiced in health centers. Engaging patients, families, and communities in their efforts to be trauma- and resilience-informed had the second-most amount of progress in 2023, with 86% of RBN survey respondents reporting at least *Moderate progress* (34% reported significant progress).

The *Patient and family engagement* cross-cutting theme also increased by 0.75 (on a 1 to 5-point scale) on the capacity assessment between 2021 and 2023. The largest change in this theme was the item, *"Our organization has a systematic strategy for seeking input on organizational strategy from patients and families,"* which increased by 1.30 from 2.20 to 3.50 (above *medium/variable*) in 2023. Six teams described work related to elevating patient and family voice in their organizations, e.g., conducting a satisfaction survey, informal conversations / interviews, check in with patient advisory board, or journey mapping / listening tour.

BRIGHT SPOT: ELEVATING PATIENT AND FAMILY VOICES TO DIRECT THE WORK OF CARE TEAMS

Children's Health Center (CHC) at Zuckerberg San Francisco General Hospital conducted a journey mapping project in 2020 to learn about the experiences of families who came to their clinic with many social and medical needs. By interviewing families, CHC explicitly invited patients to influence the ways in which they worked and the services they provided. Intentionally elevating external ideas about how care teams work was not traditionally how CHC operated and signaled a shift to a culture that values and acts on community voices. Through journey mapping, they heard families express frustration and need for support navigating the complex processes in connecting with developmental services through the San Francisco Unified School District (SFUSD).

RBN team members at CHC acted on this information by creating a toolkit to improve how families navigate the transition from services available through a regional center for children under age three, to services for children aged 3 to 5 through the school district. The toolkit is a combination of paper and electronic resources, as well as elements of the electronic medical record, and contains pre-filled forms and scripts parents can use in conversation with SFUSD.

After CHC started using the toolkit, word spread to other clinics in the San Francisco Health Network (of which CHC is a member). Other clinics asked to use the toolkit with their patients and families and CHC now shares the toolkit with all 14 members of the network. CHC has received positive feedback and appreciation for the support its toolkit provides getting kids connected to development services they deserve. More information about this work is available in CCI's feature story about CHC.

Four teams described deepened work with **community partners**, acknowledging that health care organizations cannot independently address all their patients' needs and strong relationships are needed to successfully serve their communities. In the partnership between Petaluma Health Center and school-based family advocates, team members reflected that the RBN grant was an opportunity to develop collaboration that was deeper and more trusting than most other relationships with community partners. They established a cross-organizational, multi-disciplinary RBN team that included family advocates at local schools, county partners, and clinic staff members—this was a different level of partnership from other projects within the clinic, as well as other RBN teams. They developed an open, trusting relationship that allowed them to better serve families by coordinating services between schools and clinic with warm handoffs and school-based outreach. Through this intentional investment in relationships and trust, they indicated that the partnership benefitted from:

- Health centers having paid staff to focus on partnerships
- Setting aside regular times to meet as a team with representatives from partner organizations to discuss and coordinate referral or service needs
- Being open and curious
- Listening and being receptive to honest feedback
- Being willing to creatively problem solve and work together in new ways
- Visiting each other's locations to get to know each other as people and the services provided
- Attending mutual events

Families benefit from the mutual trust between the clinic and school staff and from the reduced barriers to accessing primary and acute care services. Clinic staff and family advocate team members met regularly, and clinic staff visited school campuses throughout the district to engage with parents and their children, and to strengthen the linkage between the clinic and broader community. Both clinic staff and family advocates felt they better served their shared clients because of the partnership. They reported feeling positive about the work and part of something important. More information about this work is available in CCI's story featuring this work.

Believing in and supporting the principles of trauma- and resilience-informed cultures of care and practice was likely an important attitude to persist in and advance this culture change work and was something consistently shared by nearly all RBN participants (over 95% agreement all years). Several teams reflected on the sustainability of this work after the RBN grant period. Nine teams talked about how systems need to be built so that practices of training, seeking, and acting on patient and community input continue after the RBN grant ends. They reflected that these areas need continued attention in order for the culture to be fully embedded in their organization. One RBN team member expressed what they thought would happen if that attention was not paid, *"…if there's no intent to keep a group together, or form another group of people to invest that time [to move the work forward], it's going to go by the wayside,"* while another team expressed they were working to get organizational support for this, *"… bringing in our HR partners to have that discussion around being that trauma informed organization, with that culture, setting that stage then and there."*

Six teams shared that they were working on or still trying to figure out how to continue TRIS training after RBN funding. These teams were at different stages, from already having TRIS training built into onboarding, to not knowing how their work could be sustainable, and everything in between. As one RBN team member reflected, *"I think there's an element of maintenance that we have to do, given that there's a decay of learning and new people on our staff. There's this ongoing refresh we need to think about, that we need to consider how to keep new staff oriented to, as part of the ethos of our organization, and continue to highlight it for staff who've been here because it then signals a priority and informs our organizational culture. We've created this, and now we need to nurture it and sustain it."*

WHAT HAPPENED – KEY FINDINGS ON LEARNINGS FROM RBN

Integrating trauma- and resilience-informed approaches into pediatric care organizations is long-term, complex, culture change work. It affects all aspects of a health care organization and requires changes to individual mindsets and beliefs and demands that clinic providers and staff do their work differently. There were several aspects of RBN's design that contributed to the overall effectiveness of the program.

4 **RBN's flexible approach in meeting teams where they were at, combined with a longer, 3-year program timeframe, allowed teams to shift work to apply new knowledge and capitalize on emergent opportunities.**

There are many potential entry points to integrating trauma- and resilience-informed approaches into pediatric primary care. **RBN was intentionally built to include all potential entry points, allow for a range of activities** depending on teams' specific contexts and interests, and be complementary to

> *"That was incredible. To have a grant that gave us space to try what we needed, where the expectations were very flexible was such a gift. It's one of the best things I've ever done."*

other TRIC efforts an organization might have underway (e.g., ACEs Aware funding). This approach models how to be trauma- and resilience-informed in allowing participant voice and choice and effectively meets teams where they are and puts teams' strengths and experiences first. This contrasts with other safety net capacity building programs that commonly require a focused set of activities for all participating teams. Additionally, RBN's three-year **timeframe was longer** than many other learning collaboratives or capacity building programs, acknowledging that culture change work takes time. It also allowed for a relatively slow start to the grant for teams so they could focus on relationship and trust building. A few teams indicated they benefitted specifically from the slower pace the program set at the beginning. These aspects of RBN's design allowed teams flexibility to grapple with the work in different ways, incorporating learning, and responding to organizational changes and transitions.

There was variation across the cohort in terms of how many strategies they employed and how much their work evolved over the three years. **RBN teams worked meaningfully on between 1 and 5 strategies** during the program and only two teams employed strategies in all four program domains. Some teams focused on priorities articulated in their grant proposal or first project roadmap, while others evolved or pivoted their approach based on early learning or emergent opportunities. All but one team made progress in at least half of their strategies of focus, regardless of the total number. Additionally, several teams reported notable accomplishments from emergent opportunities that were unrelated to goals articulated early in the initiative. For example, teams' work on clinic policy and procedures illustrates the power of flexibility. These efforts were generally unplanned (i.e., not part of early roadmaps), but six teams reported policy/procedure changes that promote trauma- and resilience-informed approaches in hiring practices (including adding positions) or address barriers to patient care (e.g., no-show/late arrival/cancelation policies). See more details about these policies in the box on page 31.

Similarly, relatively **few teams had clear, concrete goals related to the cross-cutting themes** by the second project roadmap (Year 2), but having clear goals was not a necessary precursor to progress. More teams than those who had stated goals reported traction in each of the cross-cutting themes by the end of RBN. This suggests that strategies related to *how* providers and staff do their work takes more time to make actionable and operationalize, which reinforces the importance of RBN having a longer program period.

While RBN overall benefitted from an open, broad, and flexible design and implementation approach, it came with a few complications or challenges. The suite of RBN program supports often mitigated some of these challenges.

- Robust **peer support can be challenging** when teams are working on different goals since it limits the extent to which they can dig into the details of a shared experience. As a result, peer exchange in RBN either focused on higher level concepts and topics (e.g., racial justice, reflective practice, building leadership support for TRIC) or occurred through smaller communities of practice where teams had a common strategy (e.g., ACEs screening). Some teams found the individualized RBN coaching to be effective in helping them troubleshoot and tailor specific strategies to their organizational and community contexts.

- A few teams desired **more specific direction** from CCI as they designed their strategies and determined how to translate the education offered through program events into concrete action steps for their organization. This was especially true related to the cross-cutting theme of racial justice—teams struggled with how to put this value into practice. Again, coaching provided valuable, tailored support that was critical for some teams to choose what strategies to focus on.

> *"I often left [virtual learning sessions] feeling not sure what the action was. Concrete things along the way would have helped. I think we got more over the next couple of years, but in the first year I wanted more specifics."*

- **Having trauma- and resilience-informed systems (TRIS) training be optional** (versus required as it was in RBC) **resulted in lower uptake**. RBN and RBC teams who conducted robust TRIS training for staff reported on its importance as a foundational strategy to establish common language and understanding of TRIS concepts, build buy-in and support for related efforts, and strengthen team cohesion. Since this was optional, many teams missed out on establishing this critical foundation and several continued to report challenges with staff and leaders lacking clear understanding and buy-in of their work.

💡 BRIGHT SPOT: TRAUMA- AND RESILIENCE-INFORMED POLICY CHANGE

Policy changes related to patient care and human resources is a strategy that has the potential to marry trauma- and resilience-informed care and equity, diversity, and inclusion (EDI) efforts.

Six RBN teams worked to develop or modify policies and procedures to be more trauma-informed and support equity:

- Marin City Health and Wellness Center developed a **trauma-informed no-show and cancellation policy.** Prior to RBN, they did not have a policy in place and were struggling with no-shows or last-minute changes affecting patients' access to services. The newly developed policy is clear and perceived to be working (i.e., patients understand, seem more motivated to keep appointments), but is not punitive and does not exclude patients who need the most care.

- South of Market Health Center adopted a more trauma-informed and welcoming approach by changing existing **policies around no-shows and late arrivals** and removing barriers to care. They reported, *"We strive to meet our patients where they are in their health care journey, removing the guilt and shame of running late."* If the patient is late, they offer the opportunity to wait for a no-show appointment or cancellation. If no provider visits become available, a nurse will triage the patient to determine how to best support the patient's care priorities. They also removed other barriers to care for their homeless population embedded in the physical environment. For example, patients can now eat in the waiting areas and, when appropriate, in the exam room.

- After working with the RBN team at Zuckerberg Children's Health Center, a pediatrician was promoted to the **new position of Medical Director of Health Equity.** This position will be part of a new committee for health equity to respond to grievances and coach the QI team around bringing an equity lens to their work.

- Four teams worled on more inclusive **workforce policies:**
    ◊ Zuckerberg Children's Health Center is examining their hiring and retention practices with an equity lens.
    ◊ Community Medical Centers built on 10 years of work creating a safe and welcoming workplace for all. Highlights in their journey include forming a Diversity & Inclusion Task Force made up of volunteers from across the organization, establishing a Health Equity Committee as part of the quality improvement department, and creating a Chief People Officer to lead and focus on efforts to help staff bring their whole selves to work.
    ◊ Marin Community Clinics created a staff-led diversity, equity, and inclusion group that is changing policies around paid time off and work-from-home flexibility to address equity within their workforce.
    ◊ BACH's HR department conducted a compensation review and adjustment to ensure that non-salaried staff receive appropriate breaks.

5 Teams reported increased awareness and understanding about the connection between equity and racial justice and TRIC. It took time to start to translate that learning into concrete efforts.

RBN intentionally elevated racial justice as a necessary piece of TRIC. RBN's design explicitly prioritized equity and racial justice and teams were asked to set goals related to equity and racial justice in their project roadmaps. To support this work, RBN provided education from Vital Village Networks during virtual learning sessions in Year 1 on the Dignity Framework, which explains how equity, dignity, childhood adversity, and structural racism are intertwined. Additionally, the TRIS training curriculum that several teams participated in included a 40-minute module about the connection between trauma-informed care and racial justice. Coaches brought an equity and racial justice frame to their conversations with teams, and the final convening and site visits also highlighted issues of racial justice.

RBN's focus on equity and racial justice intersected with some participating organization's ongoing work in this area, at times making it difficult to discern RBN's influence. Across the cohort it was common to have equity and racial justice work occurring at the organization without a clear link to RBN, particularly in the wake of the racial reckoning movement in 2020. For example, a few organizations reported an increased commitment to equity in their organization's strategic plan or values statement, others engaged in a formal process to set up EDI committees and engage their staff to weigh in on equity-related goals.

Some teams reported alignment of their mission, values, and belief that equity and racial justice is a key priority for them but had a hard time translating their values around equity and racial justice into actions in their organizations. **Many teams struggled to articulate clear equity and racial justice goals** related to their RBN work. Only one-third of teams had clear goals in their project roadmaps to guide their work. As one team shared, *"Racial equity is something we think is really important and I really value the conversations we've been able to have, both in the learning sessions and our TRIS trainings and our group, but operationally what is the action we take? I think we struggled with that."*

About a third of the teams discussed having **mindset shifts related to equity and racial justice as a result of RBN.** This included a better understanding of personal biases and positional power, as well as recognizing and acknowledging different patient experiences based on race. A few teams called out the Dignity Framework and the site visit to 11th Street Family Health Services in Philadelphia as profoundly effecting how they see their work and relate to both coworkers and patients. As mentioned previously, these shifts took time to develop, and the longer program timeframe likely supported teams to foster deeper relationships that would allow for discussions about more complex and sensitive topics.

> *"I loved all the education on dignity-based care, racial justice and bringing that into trauma informed care. We could all use more of that because the systems are not structured to help us implement that in everyday work. That's had the most personal impact on me, in resetting the frame. Thinking, how can I be intentional about thinking about dignity as the unifying theme, really making that connection between trauma-informed care and racial equity."*

These changes were reflected in both the annual participant survey and capacity assessment. The majority (84%) of 2023's survey respondents reported *Moderate* or *Significant* progress integrating equity and racial justice into their work. The capacity assessment showed an increase in average scores in *Equity and racial justice* during RBN. Specifically, this was an increase of 0.24 in the first half of the program and an increase of 0.42 in the last year, going from 3.02 in 2021 to 3.68 in 2023. This average rating increase was driven by a few specific questions, which addressed organizational offerings (training, policies), patient language access, and valuing staff perspectives (see Figure 7).

Figure 7: *Equity and racial justice* capacity assessment items with increases of at least 0.80

Theme / item	2021 avg.	2023 avg.	Change
Organizational offerings			
Organization provides training and support to address implicit and personal biases, microaggressions, etc. among staff and in patient care	2.80	2.60	0.80
Role of organizational policies and procedures in healing trauma and supporting equity and cultural humility	2.67	3.60	0.93
Patient language access			
Processes related to responding to trauma (e.g., interactions with health care team, connection to internal services) are culturally and linguistically appropriate (e.g., responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs)	2.93	3.73	0.80
Patient education approaches and materials related to trauma are culturally and linguistically appropriate (e.g., responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, etc.)	2.47	3.47	1.00
Valuing staff perspectives			
Non-clinical staff members' unique expertise and lived experience is acknowledged as valuable to the care of our patients and families	2.87	3.86	0.99

The results of these mindset changes were more concrete work strategies that emerged in the later part of RBN. By the end of the program, nine teams described various types of work underway related to equity and racial justice, including:

- One-third of teams conducted **equity-related trainings.** Topics included TRIS and ACEs, how to discuss equity and racial justice in well-child exams, anti-racism specifically, as well as general concepts related to diversity, equity, and inclusion. Possibly due to these trainings, the participant survey showed an upward trend in respondents' strong agreement that they felt confident in their ability to address biases, microaggressions, and other harmful behaviors that they see between staff and in patient care (22% *Strongly agreed* in 2021 and 41% in 2023).

> *"We had several staff meetings focused on issues of racialized trauma and racial equity. I don't think you can talk about trauma-informed care and creating a healing organization without acknowledging some of the underlying issues that contribute to trauma in our society, systemic racism and racial inequities are a big part of that."*

- About half of teams **implemented new policies and practices** that have equity implications (see box on page 31 for details). A few teams began collecting and consulting race and ethnicity data for quality improvement purposes. For example, one team identified patterns in race and ethnicity data linked to the systemic biases experienced by their patients involved in the criminal justice and child support systems. The team worked to find ways they could advocate for fair treatment of all their patients.

- About half of teams acknowledged that it was important for **staff, providers, and leadership to reflect the diversity of their patient population** and for patients to receive services in their native language. A few reported hiring bi-cultural or bilingual staff to address a perceived gap in their staff and establishing patient advisory boards accessible to patients with native languages other than English. Other teams focused on translating materials and having staff or interpreters who speak a variety of languages.

- Two teams reported increased interest in **race-based caucusing** with staff and providers. For example, one started a BIPOC provider support group that combats isolation and is talking with organizational leadership about different culturally-based perspectives on client care. This team also started a consult group for Spanish speaking clinicians to talk about culturally appropriate services.

The extent to which this work will be sustained after the conclusion of the RBN program is subject to the same factors discussed previously related to the sustainability of mindset and culture shifts, though a few teams called out their work related to equity and racial justice specifically. As one team member reflected, *"We plan to continue to find ways to engage in the hard conversations around race within our own spaces and organization staff, in safe ways and ways that helps us grow and not be afraid to ask the hard questions and look inwards."*

6 **Internal and external supports and structures contributed to teams' ability to advance TRIC in their organization, even in the face of significant, systemic challenges.**

Throughout the program, RBN teams discussed the various pressures facing health care organizations and the myriad responsibilities health care workers juggle. Two specific, seemingly intractable, systemic challenges were consistently elevated by RBN teams.

- **Lack of time:** Teams consistently reported time constraints as the most significant and persistent challenge they faced in moving RBN work forward. Over half of survey respondents named competing priorities within the clinic as a key challenge, which often took precedence over RBN efforts. Even when the grant supported administrative or protected time for team meetings, teams struggled to find the time needed to move RBN-related projects forward. Some teams found RBN work to be time consuming—about half reflected at the end of the program that they had not had enough time for all the grant activities (e.g., roadmaps, capacity assessment, reporting, meetings).

- **Workforce issues (turnover, staff shortages):** Staff transitions are a common challenge for safety net health care organizations in programs like RBN. This challenge was exacerbated by the COVID-19 pandemic—RBN teams reported increased levels of turnover and attrition, as well as day-to-day staff shortages due to illness or employment transitions. In the 2023 participant survey, 58% of respondents reported challenges advancing RBN work due to staffing shortages, limiting work outside of direct patient care. This caused remaining staff to feel stretched thin, shifted team relationships and dynamics, and delayed work to advance RBN-related priorities. Over half of survey respondents consistently indicated that people in their clinic were experiencing overwhelm and burnout, making it difficult to add one more thing on top of their regular work (53% in 2023, down from 85% in 2021) (Figure 8). Turnover also reinforced the need to set up systems for re-training around the principles and practices of TRIC. Teams reflected that dealing with high levels of turnover was something they would have liked more help with from the RBN program (e.g., CCI or their coaches).

Figure 8: Challenges teams encountered while advancing RBN work, 2021 & 2023
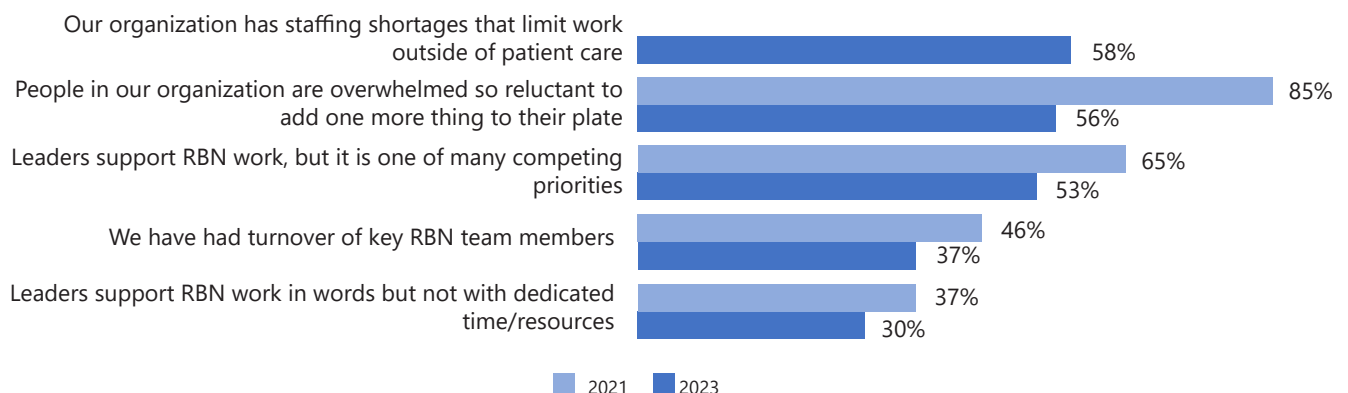
Note: *Our organization has staffing shortages that limit work outside of patient care was not asked in 2021*

Internal and external factors supported teams' progress in their chosen RBN strategies. For this report, internal factors refer to characteristics or practices within the team and organization participating in RBN, while external factors are associated with the support provided to teams by the RBN program.

Internal structures and approaches

The evaluation explored if different team or organizational factors influenced teams' progress on their chosen RBN strategies or advancing more healing cultures of care (e.g., changing mindsets). Findings reinforced how context dependent this work is—successful teams approached the work differently depending on different organizational characteristics (e.g., size and type of clinic). While nothing emerged as a guarantee of success, most teams that reported success in their RBN strategies had these three factors in place:

1. **A clear and realistic scope for the RBN effort.** RBN teams worked in organizations of various sizes and complexities. In most cases, more successful teams determined a clear scope of influence for their work (i.e., where they had some control or decision-making power) and built from there. The details of this scope differed depending on organizational context. Role and leadership purview of RBN team members (see factor 2, below) also influenced what scope was reasonable. For example, some RBN teams focused on one department or clinic where they had direct influence within a larger institution/organization while some teams in smaller health centers with administrative leadership involvement made organization-wide changes. Teams started RBN with varying levels of clarity in terms of the scope of their goals, and about half of teams shifted their goals as the program progressed. In some cases, RBN program structures like roadmaps and coaching helped teams focus and prioritize a realistic scope for their work.

2. **A multi-disciplinary team with effective leadership.** Although team structures and exact roles vary depending on context, more effective teams were typically multi-disciplinary and included primary care clinical providers and support staff, behavioral health staff, and operational staff. Teams benefitted from more consistent and stable engagement of individuals who knew the work, both in terms of care delivery processes and organizational systems and context. Either direct leadership responsibilities or access to decision makers was critical (see factor 3 below). Some teams found their team lead to be especially effective in holding the vision for and integrating multiple, core concepts of RBN into their work, including the cross-cutting themes. For example, one team's lead demonstrated how to bring self-awareness of their personal and professional positionality and power to the work. They explicitly used a racial justice lens when shaping their team's efforts with community partners, working to mitigate power dynamics between the health center and community partners, embracing a distributed leadership model, and bringing the direct service providers into the work as peers.

The multi-disciplinary teams, including the relationships, trust, and collaboration built, were also cited as outcomes of RBN. Teams reported benefits of bringing together perspectives across disciplines and providing a space for honest dialogue and support. Working with colleagues from other disciplines was a new experience for some, and they commented how positively and sustainably this affected their collaboration. RBN prompted explicit and intentional discussions among individuals about trauma, including team members' experiences with the COVID-19 pandemic, race, and power. The first year of RBN focused on strengthening relationships and developing trust within teams, which some indicated as a critical foundation for their work. Starting in Year 2 some teams reported feelings of gelling, being on the same page, and working together in a compassionate and trauma-informed way. Program investments in team building and team lead supports were well received by RBN teams. By the end of the program, many teams commented on the refreshing nature of the relationship-based team culture that RBN promoted.

> *"Having RBN has allowed us the time to develop relationships amongst ourselves so that we feel supported as a group and that overflows to taking it to our patients."*
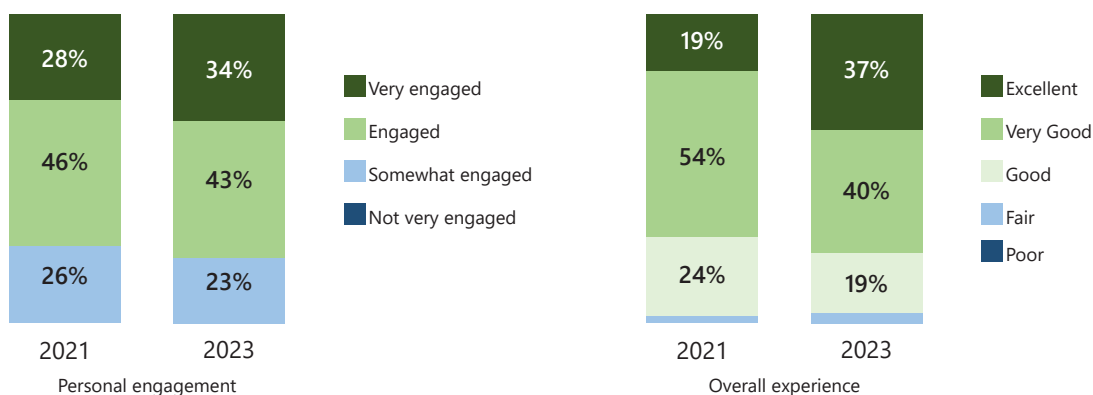
3. **Leadership engagement and support.** Teams found that leadership engagement was essential to mitigate and remove the primary barriers discussed above (e.g., dedicated staff time, help building buy-in, making TRIC an organizational priority or mandate). In interviews, half of the teams cited a lack of consistent leadership support as a barrier to making progress towards their goals, although, some were able to bring leadership in towards the end of the program. Teams progressed faster when leaders who had the power to move things forward and free up staff time for this work were involved. Some teams shared that they would have liked more help from the RBN program to create leadership buy-in by having coaches meet with executive leaders, giving leaders deliverables, or mandating that leaders participate in TRIS training.

External program supports

The RBN program was cited as a key support in helping teams advancing TRIC. **Participant feedback on the RBN program was consistently positive** and measures of experience improved slightly over time. In 2023, 77% of survey respondents reported being at least *Engaged* and indicated *Very good* or *Excellent* experience overall (Figures 9 and 10). The proportion indicating *Excellent* experience rose by nearly 20% from 2021 to 2023.

Figures 9 & 10: Experience and engagement in RBN, 2021 & 2023 (n=43-44)

Personal engagement

	Very engaged
	Engaged
	Somewhat engaged
	Not very engaged

Overall experience

	Excellent
	Very Good
	Good
	Fair
	Poor

The RBN program included a variety of resources and supports. Program offerings shifted over time based on annual program goals, feedback from teams, and evolution of teams' priorities and work. Additionally, given the stage of the pandemic in 2023, RBN held several in-person events (e.g., site visits, team leads retreats).

Figure 11: RBN supports over time

Ongoing: grant funding, access to subject matter experts and TRIC content (including TRIS training modules), peer exchange and support, program assignments (roadmaps, deliverables), online portal and email newsletter		
Year 1: • Virtual learning sessions • Monthly individualized coaching (required) • Pitch & Commit presentations to clinic/organization leadership • Film screenings (optional)	**Year 2:** • Virtual learning sessions • Strategy-specific communities of practice • Individualized coaching & technical assistance (responsive)	**Year 3:** • Open webinars on specific TRIC topics (available to CCI's network broadly) • Team leads retreats • Individualized coaching & technical assistance (responsive) • Site visits to two exemplar health centers outside of RBN • In-person closing event

While engagement and satisfaction with different elements changed over time, RBN participants overall found the most value in the virtual learning sessions, coaching, and peer connection opportunities. Additionally, in the last year of the program, team leads appreciated the in-person retreats—nearly three-quarters reported on the participant survey they had *Significant contribution* to their work.

- **Virtual learning sessions:** Team members reflected on the value of the virtual learning sessions in helping them better understand key elements of TRIC and connect with other RBN teams. They found the content from RBN faculty, including the Dignity Framework, thought provoking, inspiring, and in some cases practice changing. Teams also reported benefitting from the peer sharing that occurred in community of practice breakout sessions. These virtual events were a source of inspiration given the stressors in the health care environment during the pandemic.

> *"I don't think I would have been able to really understand it, being that this is my first experience ever in any of this [TRIC], without the opportunity to go in and hear someone speak that is an expert in all of these subjects and then be able to come back and practice."*

- **Peer connections:** Many team members reported that the peer exchange and support facilitated through RBN, mostly during the virtual learning sessions, validated their experiences, helped them feel less "alone," and supplied new

> *"I reached out to my coach and said: 'I'm having such a reaction to this email chain. How do we use this as an example to interact with each other a little differently?' I didn't know how to do this. No one ever taught me to stop and pause and listen and not be reactive with people. So, for me personally, it's been a huge area of personal growth."*

ideas for how to approach the work. During the program, many participants expressed a desire for more peer sharing and in-person opportunities to learn from each other. Some participants would have liked CCI to play a more direct matchmaking role to pair teams for peer learning. The in-person events of 2023 (e.g., team leads retreats, in-person closing event, site visits) helped strengthen these connections.

- **Coaching:** In Year 1, RBN paired each team with a coach for individualized support and technical assistance through monthly meetings. That year, coaching was the highest rated program element on the participant survey, over half (56%) of respondents indicated that it significantly contributed to their team's progress. Participants had overwhelmingly positive feedback on their coaching experience. Coaches helped connect teams with resources, provided a sounding board for strategy decisions, and helped them reflect and think differently about their work. In Year 1, some teams reported coaching had a profound impact on their ability to embody trauma-informed principles. After the first year, RBN made coaching optional and the number of teams working with coaches decreased. The extent to which this signals that coaching was perceived to be less valuable versus reflective of the overwhelming demands on teams' time is unclear. Other optional program supports (e.g., technical assistance from Vital Village or Trauma Transformed) also had limited uptake in Years 2 and 3.

Other RBN supports teams mentioned less frequently but still contributed to progress included grant funding, program assignments and deliverables, and CCI program office support.

- **Grant funding.** Grant funds that supported staff time to participate in RBN were critical for team members to move the work forward. Some teams discussed how it was easier for providers to have protected or dedicated time compared to other clinic staff. This was problematic since it exacerbated existing power dynamics and often teams needed time from colleagues who did not have protected time to move RBN work forward.

> *"I think the grant forced the organization to take certain aspects seriously. When you have a grant, we have to get this deliverable if we want to get our funding. That was an essential piece of getting things going."*

- **Assignments & deliverables.** Some teams reported that the program requirements helped them to move their work forward. They commented that when deliverables are tied to funding it gets people to pay attention and make things happen in a new way. Assignments were rated the highest when teams had to complete roadmaps articulating their priorities and strategies and present to their leadership about problems they wanted to address through RBN and their planned strategies. These requirements helped teams clarify their goals and build leadership buy-in.

> *CCI takes time to not only just personally know us. They know our organization they know what we've done. They're always our biggest supporters and champions. They've set the stage for it being such a welcoming and empowering uplifting environment, that then trickles down to what we can do with our staff. I leave learning sessions and I'm like, I can do anything!"*

- **CCI program office support.** Teams commented positively on the intentionality that CCI staff brought to planning and administering RBN. They found CCI staff effectively modeled and embodied TRIC approaches: they were kind, flexible, and relational. A couple of teams shared how this modeling rippled out to the way their team members approach their work.

A few teams reported that RBN helped position them to seek additional funding and grow their TRIC-related work. This includes providing a structure or framework for the work underway, language to describe their efforts, direction for what they can do next, and connections to showcase their work.

LOOKING FORWARD: WHAT'S NEXT IN THE JOURNEY FOR RBN TEAMS?

After the initial 3- year program, RBN teams had the opportunity to engage in a yearlong wind-down focused on sustainability. Grant amounts were smaller and program supports were more limited, prioritizing efforts that would continue to strengthen the RBN network and support teams in their next steps. At the end of RBN (2023), teams were thinking a lot about what it would take to build on and sustain the progress they had made. Teams were mixed in their projections: several were concerned about the lack of funding, accountability, and momentum while others discussed ongoing passion, commitment, and future opportunities.

Most teams were working to figure out how to continue practices without funding for protected time or additional supports. Approaches that had been (or could be) institutionalized into organizational practice or culture seemed more likely to sustain (ACEs screening, TRIS training) and some team members reflected on mindset shifts that are just part of how they now do their work. A couple teams presented their progress to

> *"Being a leader in this work, we'll be able to attract more clinicians and have more people excited in this type of a work environment by changing it from an environment where you feel like there's no hope and you're constantly asking people what's wrong with them, to an environment where you're asking what's right with you and how do we help you get more of that."*

their leadership, shared what they learned, and what was left to do at the end of the program. They found that this was a good reminder for everyone of suggested next steps. Overall, RBN produced a cohort of leaders, champions, and advocates for TRIC who are committed to continuing their journeys to have more healing cultures of care within their organizations. Teams saw it as an organizational imperative in terms of where health care needs to go, along with being the "right" thing to do for staff and the patients and families they serve.

Ideal state: RBN teams' vision for trauma- and resilience-informed models of pediatric primary care

Since RBN was intentionally designed to meet teams where they were at and did not articulate a standard template for what trauma- and resilient-informed models of pediatric primary care needed to entail, teams program efforts varied. At the end of the program, the evaluation asked teams to reflect on the ideal vision of trauma- and resilience-informed pediatric practice. Teams' visions were relatively consistent, informed by their experience with RBN. They centered are three themes: trauma- and resilience-informed patient care, staff support, and physical clinic environments.

Patient care. Most commonly, teams described healing interactions with patients and families as the ideal state for trauma- and resilience-informed pediatric practice. This included inter-personal interactions that built connection, made patients and families feel safe by being warm and non-judgmental and using eye contact. Several teams discussed using a strengths-based, whole-person

> *"In our visits we spent a lot of time letting the patients be the experts and listening... you're looking at the patient, you're connecting with them, you're listening to them more than filling out a note template."*

approach that situates the patient as the expert, ensures patients and families are listened to, and responds to their priorities while still providing accessible patient education and guidance. Three teams reflected that more racial concordance between providers and patients would promote these types of interactions.

Several teams noted the organizational and systems changes required to provide this type of care. Specifically, over half of teams raised the need to be able to connect patients and families to the services and supports they need, either internally or through referrals. Internally, this would benefit would include a multi-disciplinary team onsite that can provide wraparound services with warm

handoffs. Externally, it requires services be both available and accessible for patients and families.

Some observed that having time is the primary barrier to doing this work and systems-level reforms are needed to allow flexibility for longer patient visits. Others noted the need for ongoing work to build healing cultures of care by establishing common language and understanding as well as providing ongoing training and support on aspects of TRIC

Staff support. Over half of the teams focused on "caring for the carers" as a core component of a trauma- and resilience-informed pediatric care model. They reflected on how commonplace vicarious trauma is in their organizations and advocated for dedicated time to address secondary trauma by debriefing challenging encounters, providing support and space to step away and decompress. Teams envisioned building a team-based culture that recognizes and supports each other, celebrates successes, and builds community.

> *"I sat and cried with a patient who told me about her childhood trauma... how do we have time to then unpack that and have a team meeting and share in the collective grief and the celebration that we get to help patients in this way that is totally amazing... We need a weekly debrief session that cares for the carers."*

> *"A place that is warm and playful and feels gentle and useful for children and families to be, where they see themselves in the building and its structure and its art and its people."*

Physical clinic environment. Less commonly, teams described changes to the physical clinic environment as a contribution to their TRIC model. Their clinics would be child-centered and reflect the cultural diversity of the communities they serve, as well as physically accessible. A couple of teams described the ways in which a TRIC model would stretch beyond the clinic walls to community events and community-based service planning efforts to meet people where they are.

CONSIDERATIONS

Based on teams' progress during RBN, along with reflections by program partners and CCHE's experience evaluating other similar initiatives, the evaluation team offers the following considerations for ongoing or future investments in trauma- and resilience-informed care initiatives within health care organizations. These considerations are offered primarily with program funders, designers, and implementers in mind. When they also include potential implications for health care organizations, that is stated explicitly.

1. Given the various entry points to advancing trauma- and resilience-informed care, **funders and program implementers need to determine the goal(s) of an investment and design and fund the program in accordance with the goal.** This requires weighing trade-offs in determining the breadth and depth of this type of program, making decisions about which program elements to include, and appropriately messaging and managing expectations with program partners such as coaches, content presenters, and technical assistance providers.

    a) Programs that are broad in nature, like RBN, offer flexibility in what teams can work on, helps meet teams where they are, and model trauma- and resilience-informed approaches. Trade-offs of this flexibility include implications for the participating teams: the level of depth the curricula, training, and peer learning can go into may not be specific enough to be relevant and broad topics may foster uncertainty in knowing what to do and where to focus their work. There are also trade-offs for communicating the impact of the program, as flexible approaches and broad content areas introduce limitations for evaluation in terms of having consistent (quantitative) metrics and also may not lend themselves to telling a cohesive story about an initiative.

    b) Programs that are less flexible or have a more narrow and consistent focus (e.g., ACEs screening, staff training) allow for deeper content delivery and peer exchange since all teams work on a similar project. It can be easier to require measurement on specific metrics and simplify communications about the impact of an investment. The program can often provide clear, specific guidance to teams. Trade-offs of this approach include the program approach not aligning with teams' context, an inability to be responsive to feedback and changes either external or internal to the program, and potentially not modeling or embodying a trauma- and resilience-informed approach.

    As discussed in finding 6, RBN's approach of including all aspects of trauma-and resilience-informed care offered teams flexibility and effectively met teams where they were in their journeys to become healing organizations, given their organizational context. RBN successfully advanced many different aspects of TRIC and provided program supports that contributed to teams' progress. Overall, RBN appeared to have mitigated some of these trade-offs by having a suite of different program supports at different levels (e.g., learning sessions, coaching, technical assistance). But there was also evidence of the tension between flexibility and precision when teams reflected that program content or peer learning was not specific enough to be relevant or actionable for their contexts or when they requested specific guidance about how to do this work. For example, coaching that provided detailed support was highly valued by teams, but the impact of coaching declined when it became optional and responsive in Year 2, and many teams stopped using it. At the same time, teams continued to struggle with RBN's cross-cutting themes, needing more individualized support, concrete examples, and support to clarify goals and determine strategies.

    There is not one right way to implement trauma- and resilience-informed care, and no single starting point that would be perfect for all organizations or programs. There are multiple potential entry points and various ways to build momentum and sequence the work depending on

organizational context and priorities. Teams doing this work must choose a starting point that is logical and relevant for their organization. Organizational leaders can facilitate the process by holding the long-term vision and providing necessary support to advance the work in a human-centered, integrated way (e.g., time, resources, relationship building, training). It can be helpful to start in a specific part of the organization, such as a specific site, department, and/or team. For RBN, the population of focus (children ages 0-5) prompted organizations to situate their work in pediatric clinics or care teams. Starting in a specific part of the organization may help clarify the scope of the work and make it easier to pilot changes, see progress, and build momentum to spread to other parts of the organization. However, there are implications for spread—it may be challenging and require additional, intentional efforts to engage other departments or influence the entire organization.

Program designers, implementors, and funders should weigh these pros and cons in the context of the goals and level of their investment and find a feasible balance that will best support their goals. The Resilient Beginnings portfolio provides a window into a somewhat more prescriptive program through Resilient Beginnings Collaborative where teams were required to complete organization-wide TRIS training and report data on ACEs screening (essentially requiring teams to prioritize ACEs screening). These two requirements did not always fit participating teams' interests or readiness, but it did allow for more in-depth content delivery, peer exchange, and measurement in those areas.

2. **Staff training on trauma- and resilience-informed systems (TRIS) that includes time for discussion and reflection along with content, is necessary and a critical foundation for doing this work.** Training establishes collective understanding and shared language of trauma- and resilience-informed cultures of care. It builds important relationships and fosters buy-in and momentum for the work that follows. All of this is important groundwork for various other aspects of trauma- and resilience-informed care. Resilient Beginnings saw the benefit of this being a program requirement during Resilient Beginnings Collaborative. In RBN, when TRIS training was optional, only a handful of teams participated and they consistently reported progress related to mindsets shifts and signals of organizational culture change, which are precursors to implementing trauma and resilience-informed systems. This suggests it is an effective foundational strategy that is worth the effort it takes to implement in a robust way (e.g., logistics and coordination, time in planning and conducting, facilitation for reflective discussions). For funders, program designers, and implementers, this suggests that early investments and support in training may be needed to effectively implement aspects of TRIC. For health care organizations, prioritizing foundational TRIS training could be important work to move the whole organization along in its journey to a more trauma- and resilience-informed culture. Although it can be logistically difficult, the benefits likely outweigh the challenges for most teams/organizations when implemented effectively (with space for discussion and reflection).

3. **When ACEs screening is implemented alongside broader TRIC concepts, both care teams and patients are more supported, and it ensures screening is helpful versus harmful.** Both Resilient Beginnings programs confirmed that health care organizations see ACEs screening as a promising entry point to being more trauma- and resilience-informed. Both programs also reinforced the importance of situating ACEs screening within a larger effort to build more trauma- and resilient-informed cultures of care. Teams agreed that the ACEs screening form is a tool, and the value of screening is in the resulting conversation between care team, patients, and families. Screening is most beneficial when it is part of relational, coordinated, and holistic/whole-person care practices. This requires foundational work and supportive structures beyond the technical aspects of administering the screen such as:

    a) Staff training in several areas: potentially TRIS or similar training; the purpose or "why" of screening; practice aspects like workflows, data systems, and follow-up or referral systems; role plays related to the in-visit conversation.

    b) Intentional and explicit efforts to integrate discussions of resilience and patient and family strengths.

    c) Integrating a role like a care coordinator or case manager to provide training and support to staff administering screening, be a resource and warm handoff for providers, assist with follow-up, referral, and closing the loop, and offer explanation and continuity for patients.

    d) Processes and space for staff to decompress and debrief difficult encounters with patient and families.

    Funders, program designers, implementers, and health care organizations must be aware and account for the supplemental work required to administer screening in a trauma- and resilience-informed manner.

4. **Programs focused on TRIC must intentionally include goals and resources related to supporting staff and provider wellbeing—this was a unique value add of RBN, addressing a needed gap but very challenging given the culture of the safety net.** Although not a primary focus or priority of the first Resilient Beginnings program, RBN reinforced the importance of staff support given known contextual challenges related to the health care workforce, including the reactive culture and stressful environment in clinics, high levels of burn-out among health care providers and clinical support staff, COVID-19 pandemic-related attrition, and the risk of secondary of vicarious trauma when doing this work (both implementing TRIC and providing health care more generally). RBN not only elevated this as a priority but modeled how to incorporate associated practices (e.g., mindfulness moments, reflective spaces) that some teams incorporated into their own environments. Doing trauma- and resilience-informed care and equity and racial justice work in a health care context can be emotional and taxing, so stepping back to regularly and systematically "care for the carers" is needed to sustain and advance the work. Funders, program designers and implementers, and health care organizations should consider investments in staff and provider support and wellbeing a central tenant to trauma- and resilience-informed care versus an optional add-on.

    Teams' reflections about supporting staff and provider wellbeing both elevated its importance and wondered about its impact. There are opportunities to further explore how to assess, understand, and potentially strengthen the impacts of this work. Many efforts in RBN were brief in nature or light touch—what are the effects of all these efforts together? Are they positively affecting morale, workplace culture, and ultimately patient care?

5. **The RBN themes related to ways of working—Equity and Racial Justice, Strengths-Based Approaches, and Patient and Family Engagement—took more time and support to understand, digest, and operationalize than clinical processes such as ACEs screening. The evaluation largely found that transformation in these areas centered on teams shifting their thinking from the what to the how of providing care and required embodying or holding this orientation in all aspects of teams' work.** RBN introduced these concepts early in the program, but many teams initially struggled to see how to apply the cross-cutting themes to their RBN work and requested more concrete guidance and examples of how to operationalize these concepts. All three themes saw more growth later in RBN as teams became more familiar and comfortable with TRIC approaches. Advancing their RBN work effectively often did not mean doing more, rather involved changing how teams thought about and approached what they were already doing.

Equity and racial justice in particular was a unique and appreciated focus of RBN—teams reported seeing the value of explicitly grappling with race and power in safety net health care, particularly given the national cultural context during RBN. Still, teams reported challenges knowing what to do or what equity and racial justice work could or should look like in their organizations. Advancing equity and racial justice work in health care organizations may require teams and organizations to shift their general orientation or culture to focus on and adapt process versus only driving towards outcomes.

Additionally, in their attempts to elevate patient and family voices, teams frequently cited time as a barrier. However, there may have been a stronger barrier related to changing how clinic systems see patients and value their input indicating a deeper cultural shift would be necessary to truly elevate their voices in influential ways.

Implementing *Strengths-based approaches* appeared to be somewhat easier for teams, perhaps due to the number of teams doing ACEs screening as part of their RBN work. Direct patient care may have been a clear entry point to incorporating strengths.

Programs that incorporate or focus on these more complex topics will likely need to be on a longer timeframe to see concrete progress or action. They may also need to build in supports for reflection and attention to process, as well as celebration for seemingly small changes or shifts.

6. **Advancing TRIC is complex, long-term, cultural change work that benefits from a stable, multi-disciplinary team with effective leadership, the ability to articulate a clear and realistic scope, and engagement of and access to people who can authorize and meaningfully support its implementation (i.e., organizational leaders and decision makers).** These factors facilitated progress for RBN teams from organizations of different types and sizes. The stability of teams' membership (especially in the lead roles) supported progress, regardless of the level of complexity in the teams' composition. The biggest threats to progress were: unrealistic/unclear scope (i.e., teams not knowing where to start or what first steps should be), lack of meaningful organizational or clinic leadership support, turnover both within the team and among colleagues needed to advance RBN work, and having inadequate time for the work.

   For funders, program designers, and implementers, supporting the facilitators and mitigating the barriers is critical for program success. RBN did this through multi-pronged support such as individualized coaching and technical assistance, and complementary program requirements (e.g., establishing a multi-disciplinary team), organizational leadership engagement strategies, requesting roadmaps/project workplans as deliverables. The first two barriers (scope and leadership support) were organizational and more easily addressed through program supports like coaching while the second two (turnover and time) are persistent, systemic challenges in a fee-for-service, health care environment. Funders, program designers, and implementers need to continue to grapple with and innovate in how they support teams' success in the face of these more systemic challenges and potentially consider additional, complementary programs or investments that support more policy advocacy or systems-oriented interventions.

APPENDIX A: OVERVIEW OF RBN TEAMS

Organization name	County	Organization type	# of clinic sites[9]	# of patients served annually[10] (estimate)	Main focus of RBN work
Alameda Health System—Highland Pediatrics	Alameda	FQHC (public hospital setting)	4	9,000	• Environment: staff training (TRIS, HOPE), staff support activities (incorporating reflective practice and staff retreats) • Clinical practices: implementing ACEs screening, collecting related client feedback, strengthening referrals, incorporating resilience practices.
Alliance Medical Center	Sonoma	FQHC	2	1,223	• Clinical practices: training, developing workflow and engaging providers for ACEs screening (including PCEs). Established patient advisory council. • Environment: staff training (TRIS, HOPE), policies related to EDI, staff wellness, reflection. Hiring CHWs.
Bay Area Community Health	Alameda, Santa Clara	FQHC	7	6,393	• Environment: hiring behavioral health staff, implementing No-Hit Zone. • Clinical practices: developing workflow and implementing ACEs screening, building EPIC and pediatric care coordinator supports, exploring expanding to screen pregnant people, incorporating strengths focus.
Children's Health Center—Zuckerberg San Francisco General Hospital	San Francisco	FQHC (public hospital setting)	2	3,343	• Environment: staff training (TRIS, HOPE), staff support activities (incorporating reflective practice and staff retreats) • Clinical practices: implementing ACEs screening, collecting related client feedback, strengthening referrals, incorporating resilience practices.
Community Medical Centers	Solano	FQHC	22	17,201	• Environment: staff support. • Clinical practices: workflow and implementing ACEs screening including strengths, building up referral system with care coordinator role.
LifeLong Medical Care	Alameda, Contra Costa	FQHC	7	6,607	• Environment: staff support, TRIS training, established No-Hit Zone. • Clinical practices: workflow and implementing ACEs screening including resilience questions. Established patient advisory council.
Marin City Health and Wellness Center	Marin	FQHC	3	234	• Environment: TRIS training, staff supports, trauma-informed policies and clinic design. • Clinical practices: integrating behavioral health and case management teams including referral tracking.
Marin Community Clinics	Marin	FQHC	3	4,471	• Clinical practices: Healthy Steps implementation, coordination between pediatrics, complex care and behavioral health departments.

[9] Sites providing primary care for children 0-5 years
[10] Patients ages 0-5 years

Organization name	County	Organization type	# of clinic sites[9]	# of patients served annually[10] (estimate)	Main focus of RBN work
Petaluma Health Center— Coastal Health Alliance	Sonoma	FQHC	4	4,160	• Environment: staff support, anti-racism trainings and policies. • Clinical practices: workflow, training and implementing ACEs screening. Patient navigator referral support, collecting screening-related client feedback. Deep partnership with family advocates in schools and behavioral health coalition.
South of Market Health Center	San Francisco	FQHC	2	287	• Environment: staff support, trauma-informed policies. • Clinical practices: training, workflow and implementing ACEs screening including Community Health Workers.
San Mateo County Health, San Mateo Medical Center	San Mateo	FQHC (in county public health department)	5	6,129	• Environment: staff and patient wellness, trauma-informed training. • Clinical practices: training, workflow and implementing ACEs screening including resilience.
Santa Rosa Community Health Centers	Sonoma	FQHC (public hospital setting)	5	4,669	• Environment: patient and staff wellness focus, TRIS training, resilience-focused templates, new clinic for patients who are homeless. • Clinical practice: integrate substance-use disorder case manager to team, screening for substance-use disorders, mental health, ACEs including resilience and social determinants of health.
School Health Clinics of Santa Clara County	Santa Clara	FQHC	6	865	• Environment: staff wellness focus informed by staff survey. Integrating reflective supervision & meditation, brought TIC to new behavioral health team, implementing No-Hit Zone. • Clinical practices: implementing ACEs screening including resilience, strengthening internal referral resources, building custom report in EPIC for tracking screening data. Implementing social determinants of health screening.
UCSF Benioff Children's Hospital Oakland	Alameda	FQHC	1	3,500	• Environment: staff support • Clinical practices: building leadership support for ACEs screening, developing screening workflow and training providers.

APPENDIX B: EVALUATION METHODS

The table below presents details on each of our four main data collection method, what it entailed, who participated, and how the data were analyzed. After each data source was analyzed (per the descriptions below), we looked at results across methods to triangulate data and develop the key findings presented in this report. While some key findings rely more heavily on a single data source, all were derived from a mixed-methods, thematic analysis. More informal data collection (e.g., coaches' reflections, observation of RBN events) aided data interpretation and shaping of findings.

Method	Description & Analysis
Organizational capacity assessment	The RBN organizational capacity assessment was developed by CCHE, primarily adapted from the American Institute for Research's Trauma-Informed Organizational Capacity Scale, the System of Care Trauma-Informed Agency Assessment, and the Pediatric Integrated Care Collaborative framework, in consultation with subject-matter experts, RBN faculty and coaches, and CCI staff. It was designed to help RBN teams assess the extent to which practices and systems that contribute to effectively implementing TRIC are currently in place at their organization. The assessment aligns with the four RBN domains (organizational environment, prevention and promotion, clinical practices, and authentic community engagement) and the three cross-cutting themes (equity and racial justice, patient and family engagement, and strengths-based approaches). It also includes a self-assessment of the organization's current status related to becoming a healing organization. Organizations were asked to engage a multi-disciplinary team with various perspectives (i.e., staff and leadership across clinical and operational roles) to complete the assessment. The assessment was first completed by individual team members; the team then discussed responses and came to consensus on an answer that was submitted via a REDCap online survey. Teams completed the assessment three times—baseline in January 2021, midpoint in May 2022 and final in August 2023. Responses were received from all 15 RBN organizations. *Analysis:* Domain-level and individual-item averages were calculated for both individual teams and the cohort as a whole using Microsoft Excel. Individual organization reports summarizing teams' responses with a comparison to the full cohort's response (baseline) or their teams' baseline results (midpoint and final) were developed by CCHE and shared with teams. Due to the small number of teams, capacity assessment data were limited in terms of power to detect statistical significance. Statistical tests were not performed on these data to avoid erroneous conclusions given the probability of Type II error.
Participant survey	The RBN participant feedback survey was designed as a collection of Likert-type scale questions, multiple-choice questions, and open-ended questions that assessed participants' perception of progress towards RBN program outcomes, contribution of specific program components, and benefits and challenges of the program. The survey was sent to all RBN program participants and administered online via REDCap survey platform at three points in time: December 2021, December 2022 and October 2023. Results were used to inform program improvement efforts and final reporting. *Analysis:* Cohort-level averages were calculated using Microsoft Excel. Response rate in 2021 was 59% (56/95), 46% (43/94) in 2022 and 46% (44/95) in 2023. Changes over time were interpreted cautiously due to the differences in number of respondents. Some comparisons were made based on participant roles and differences are noted where appropriate in the narrative. Statistical significance tests were performed on survey items that RBN could reasonably have expected to change during the program (knowledge, attitudes, behaviors) using SAS 9.4 software. When significant differences were present, it is noted in the text.

APPENDIX B: EVALUATION METHODS (CONTINUED)

Method	Description & Analysis
Team interviews	Interviews with representatives from each RBN team (N=15) were conducted to gather teams' reflections on RBN work, learnings and progress, success factors and challenges, and feedback on the RBN program. Between 1 and 9 people participated in the interviews including RBN team leads and other key players involved in the implementation of TRIC. Participants held a broad range of roles including primary care and behavioral health providers, clinical support staff, patient care coordinators or navigators, and administrative leadership. Interviews occurred annually with each team. The interview protocol comprised a variety of topics related to TRIC, including: • Progress and lessons related to RBN's domains and cross-cutting themes • Facilitators and barriers • Measurement related to TRIC • Feedback on participation in the RBN program In 2021, teams were asked about the breadth of potential strategies related to TRIC to assess status and areas of focus. In 2022, portions of the interview protocol were tailored to teams' priorities for deeper inquiry into 1-2 focus areas or strategies, as well as some consistent questions related to measurement, program feedback, and impact. In 2023, teams were asked additionally about the composition of their team and how that affected their work, what the ideal state of trauma- and resilience-informed pediatric care would look like for their organization, and their thoughts on sustaining their work beyond the grant. ***Analysis:*** Interviews were digitally recorded and transcribed. CCHE coded and conducted a thematic analysis of the transcripts. Codes were developed a priori, based on the interview protocol, and empirically, based on emergent themes. Coded data was analyzed and summarized into a code memo or summary.
Document review	Program requirements for RBN teams included project roadmaps (Years 1 and 2), pitch and commit presentations (Year 1), and quarterly reflection reports (starting July 2021). ***Analysis:*** Quarterly reflections were coded and CCHE conducted a thematic analysis that was combined with qualitative data from participant interviews. Project roadmaps, storyboards, and pitch and commit presentations were informally reviewed for supplemental information to incorporate into the evaluation.
Faculty reflections	The evaluation facilitated discussions with RBN coaches, program staff, and subject matter experts to reflect on evaluation finings and gather additional insights about RBN teams' work. Information from these discussions was informally integrated into the evaluation and informed data interpretation from the methods listed above.
Observation of program events	CCHE participated in and observed RBN program events including virtual learning sessions (including community of practice discussions), webinars, pitch and commit presentations, and the final in-person convening. These events provided additional insights and context that was informally integrated into the evaluation and informed data interpretation from the methods listed above.