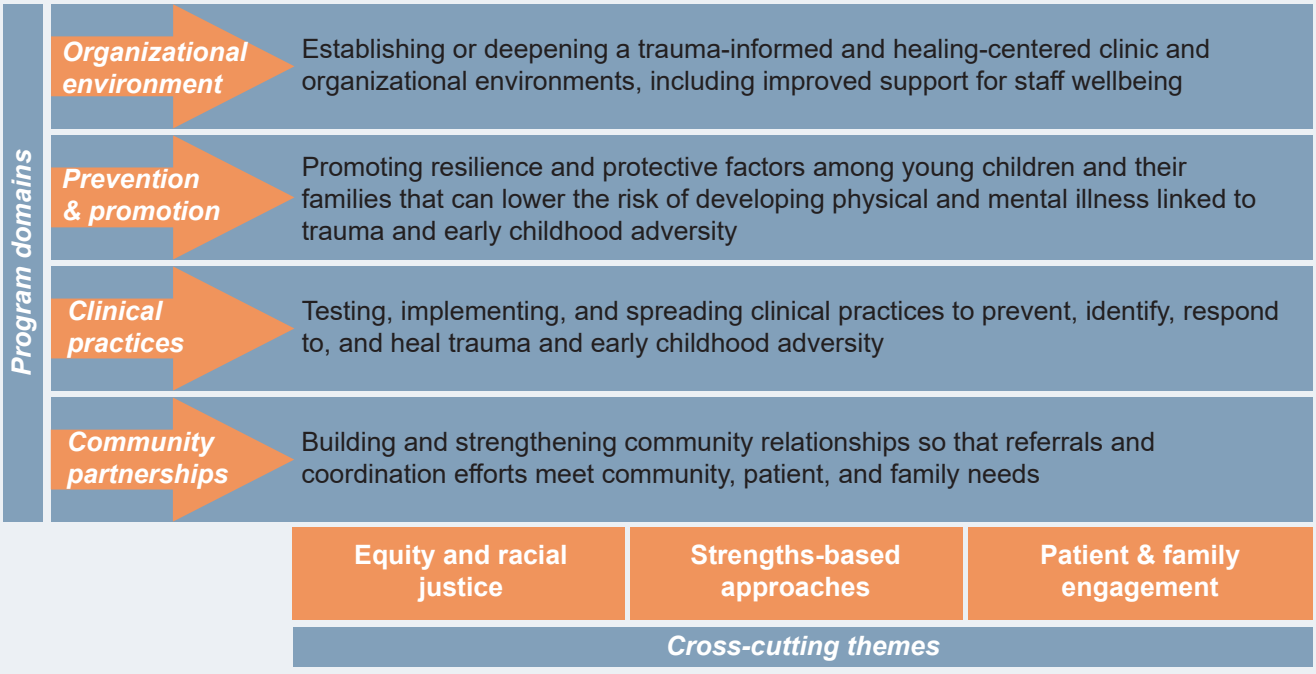
Resilient Beginnings Network: Final evaluation report

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.



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.

[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.

> *"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."*

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:

- **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.

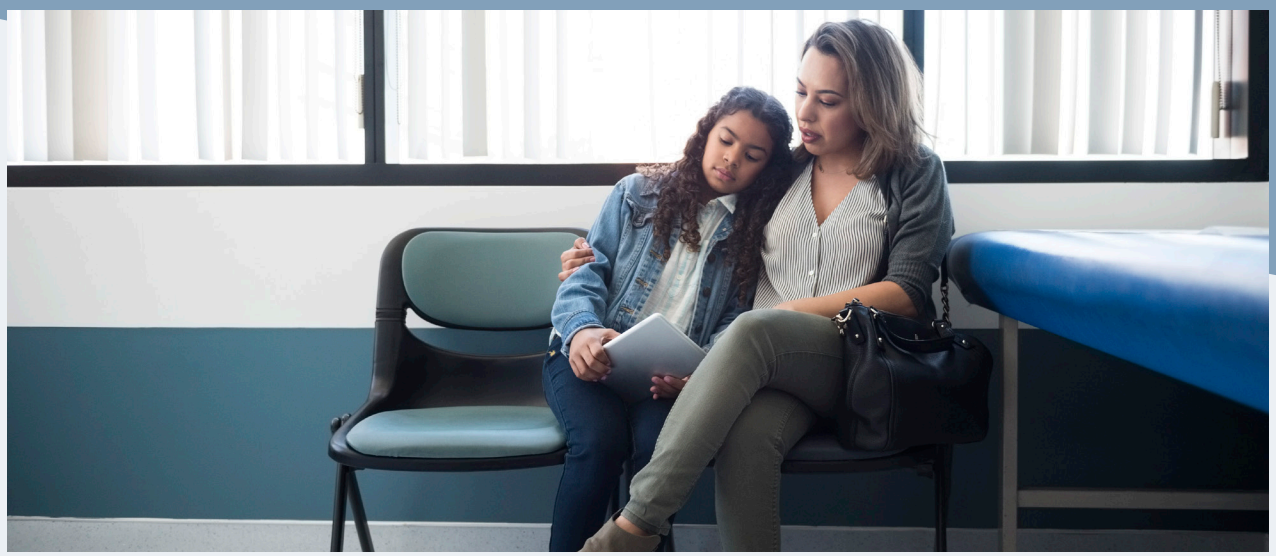
Beyond each team's specific strategies, **RBN provided opportunity for organizations to grow in every aspect of being trauma- and resilience-informed.** In the RBN organizational capacity assessment, average ratings of all program domains and cross-cutting themes increased from the beginning of RBN (between 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.

More detailed information about the findings and considerations in this summary can be found in the full RBN evaluation report.

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This report was prepared by the Center for Community Health and Evaluation (CCHE) as part of the RBN evaluation with funding support from the Genentech Charitable Giving. CCHE designs and evaluates health-related programs and initiatives throughout the United States. For more information about the RBN evaluation, please contact Lisa Schafer at lisa.m.schafer@kp.org.