RESILIENT BEGINNINGS: TRIS TRAINING TOPICAL LEARNING BRIEF

INTRODUCTION

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 to working with patients and communities. Though trauma-informed care is gaining traction in healthcare, trauma-informed organizational change is relatively new. In a time when our healthcare workforce is depleted, organizations are stretched thin, and the emotional and physical needs of the community are greatly elevated, systemic organizational change is necessary.

The Center for Care Innovations (CCI) and Trauma Transformed collaborated to provide Trauma and Resilience Informed Systems (TRIS) training to clinics participating in the Resilient Beginnings Network (RBN) (see Box 1 for more information). The TRIS training was designed to be a foundational step in clinics' transformation efforts and in their journey toward being healing, trauma reducing organizations.[1] It was designed specifically for staff in medical clinics and hospitals to understand how trauma and stress, including socio-cultural trauma, impacts developing bodies and brains, communities and organizations, and strategies for individual and organizational resilience. Together, four video modules (see Box 2) equip participants with a shared language and understanding of what it means to be a trauma-and resilience-informed organization and apply common practices to support the wellbeing of patients and staff.

BOX 1: RESILIENT BEGINNINGS

The three-year Resilient Beginnings Network launched in November 2020 and supports 15 safety net organizations in the San Francisco Bay Area to advance pediatric care delivery models that are trauma- and resilience-informed. Each organization has a multi-disciplinary "RBN team" of between four and ten people dedicated to implementing the initiative.

[1] Trauma Transformed defines a healing organization as an organization 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.

TRIS training was one tool the RBN initiative provided teams and was often situated within a larger picture of clinics' varied journeys toward being trauma- and resilience-informed organizations. Prior to the COVID-19 pandemic, Trauma Transformed conducted TRIS training exclusively in-person. In response to the limitations on in-person gatherings and the broader shift to more virtual interactions brought on by the pandemic, CCI and Trauma Transformed created video modules of the TRIS trainings and are still learning about their effectiveness.

BOX 2: TRIS TRAINING CONTENT AND APPROACH

Participants had access to four video modules, visual learning aids and optional coaching. CCI and Trauma Transformed recommended participants view the 45–60-minute videos in sequence at their own pace, either individually or in groups. The first two modules served as foundations for understanding, while the last two supported application. Additionally, teams rolling out the trainings were encouraged to include discussion of the modules as part of their implementation.

MODULE 1:
Understanding stress and trauma

MODULE 2:
Reducing structural racism and bias

MODULE 3:
Strengthening resilience and promoting safety & sustainability

MODULE 4:
Cultivating compassion & trust and fostering collaboration & agency

As part of the RBN evaluation, the Center for Community Health and Evaluation (CCHE) spoke with RBN teams from five organizations who opted to implement TRIS training during Year 2 of the initiative. These organizations included:

- Three independent Federally Qualified Health Centers (FQHC) and two FQHCs housed within public hospital systems
- Located in Alameda, Marin, San Francisco, and Sonoma counties
- Varied in size: one serving under 500 patients aged 0-5 annually, one nearly 10,000, and the rest between 1,000 and 5,000
- Operate between 2-5 sites that provide primary care for children ages 0-5

Learning from these organizations' experiences[2] can provide guidance to other health care organizations that are interested in or already implementing TRIS training. This brief describes the various approaches taken to implement TRIS training, shares challenges and lessons RBN teams learned during the process, and highlights benefits they experienced. It concludes with implications for future implementation of TRIS trainings.

[2] Not all teams who opted-in to TRIS training in Year 2 had fully rolled it out by the end of the year; data are incomplete in those cases.

LESSONS LEARNED AND CHALLENGES FROM IMPLEMENTING TRIS TRAINING

RBN teams that opted-in to TRIS training implemented in a variety of ways depending on their organizational contexts. **As they prepared to roll out TRIS trainings, teams considered:**

- Whether they would conduct the trainings (i.e., present the video modules) in person, online, or a hybrid of both. While some teams perceived in-person as preferable, they also acknowledged that some of their staff were primarily remote, and inclusion was important
- Power dynamics that may be in effect if trainings were conducted with different staff levels and roles together, compared to providing trainings within role groups, which may provide a feeling of safety
- The financial aspects of dedicating the time to conduct trainings, for example if they occupied the time of an entire department for an afternoon to watch the modules instead of seeing patients
- How and when they would facilitate discussion and reflection after the training modules, either concurrent with the modules or asynchronously, especially the module related to structural racism and bias

Several lessons can be elevated from the experiences of the RBN teams who began TRIS training in 2022:

Preview the content: Most began by **first watching the TRIS training videos within their RBN team to understand the content** and strategize how to best roll out the trainings in their organization's context. One team realized that their clinic leadership team needed to be exposed to the trainings first, before showing them to the entire clinic. They began sharing clips from the trainings and facilitating discussion at monthly leadership meetings about three months prior to offering the training to clinic staff. A different team also thought it would be valuable for their leadership to see of the training modules to build skills and awareness of TRIS concepts and practices.

Start with a pilot: Most teams implemented a post-module reflection and discussion session and **piloted the process in their RBN team before expanding** to other colleagues. This allowed them to understand the time it would take to conduct the trainings, experience the proposed discussion structure themselves, and problem solve before moving ahead. Several RBN teams identified that finding, dedicating, and prioritizing **time was a main challenge**. One team attempted to mitigate this by blocking time on people's calendars to watch the videos but had mixed success because people still reported they did not have time to watch the modules. Another team gave staff time out of clinic to participate in the trainings, which they said was helpful.

> *"Definitely carve out time because otherwise it won't happen."*

Teams varied in how widely they expanded after the pilot: either expanding to their entire clinic or organization or deciding to do the trainings in waves, for example department by department or with a smaller champions group before larger units. By the end of 2022, some teams were farther along in their roll out of the trainings than others, for example one team reached nine people with all four modules and another team reached 85 people (and 13 additional people with at least one of the modules).

Include time for discussion: Among the implementing teams, the roll out happened mostly asynchronously, i.e., individuals watched the training modules on their own time and then came together in groups a week or a month later to discuss with other people. RBN teams have been holding between two and four discussions after the modules, either after each module or after the second and fourth modules. Most discussions were in small groups of up to 8 people in diverse roles or different jobs in the clinic.

Multiple teams indicated that the **discussion after viewing the modules was the most valuable part of the training**, helping to build relationships and reflect on the content. One team described the discussions as "excellent" and noted how engaged people were, sharing personal stories, and speaking respectfully to one another. Another team said, *"Part of what makes the modules helpful is the opportunity to discuss the contents for shared learning and brainstorming about ways to make the concepts real in the day-to-day hustle of the clinic."*

Having **discussion across roles was also seen as beneficial** and a good way to get people to connect. One team shared that speaking in cross-role groups was helpful modeling and prepared people to have these kinds of conversations in the future and in different settings. Another team spoke positively about it providing an opportunity to talk to people they may not have interacted with before and make new connections.

> *"You can be in a breakout room with a doctor, a tech and yourself, and everyone has different perspectives, they see different things on a regular basis. It is very interesting to hear everyone out."*

Consider how to embed and sustain learning: One team worked with their Human Resources department to upload the videos to their online training platform, which was able to track completion. They and one other team indicated the TRIS trainings are now assigned to all new hires to complete during onboarding, which can alleviate the time challenge, while also communicating the trauma- and resilience-informed culture of their clinic. Making sure new staff receive the training also has the potential to ease another identified **challenge of staff turnover**, which affects the clinic because TRIS knowledge leaves when staff leave. To keep the training concepts top of mind, one team that implemented earlier in 2022 indicated they have had some success bringing the training themes to their monthly staff meetings.

OUTCOMES & IMPLICATIONS

After implementing TRIS training, RBN teams[3] observed several positive outcomes:

- **Staff are more sensitive in relating to others:** Three teams noticed that staff behavior toward patients was more patient and sensitive, and two teams suggested this was happening in interactions among the care teams as well. Two teams described these shifts as subtle, but valuable, one team noting, *"Even just one little takeaway from [TRIS training] to a nurse or an admin or a provider to change the way that they're interacting with the mother or the father increases their likelihood of coming to the clinic and trusting the provider."*

- **There is common language about TRIS work & why they do it:** Two teams spoke positively about the shared language that TRIS training gave their clinic / organization, providing helpful framing for care teams as they navigate the day-to-day demands of the clinic.

> *"I have noticed improvement in the shared language and how it's impacted positive culture within our organization."*

- **Training communicates that the clinic / organization values TRIS:** Dedicating time for TRIS training can be a signal that the concepts and practices are supported and valued by the organization. In conjunction with the post-module discussions, one team noted, *"It has been positive to actually talk about this stuff and really show that we're not just doing lip service but we're bringing it in all the time."* Additionally, including TRIS training in staff onboarding can set the tone for new staff and underscore that the clinic / organization wants to foster a more trauma and resilience-informed culture.

Importantly, not all aspects of the training were positive. One team noted the difficult – and sometimes triggering – nature of some of the topics covered by the TRIS training modules (e.g., describing the depth

[3] Some teams attempted to solicit feedback about the training from participants but had relatively low response rates and therefore little direct feedback or information on outcomes from the participant perspective.

and pervasiveness of racism) but emphasized that the conversation was necessary. Trauma Transformed has been considering what scaffolding may be needed in the virtual roll out to help clinics facilitate these discussions with care and sensitivity. One team had been sharing basic concepts about trauma- and resilience-informed care in monthly staff meetings for about a year prior to rolling out TRIS training and said it was useful preparation to frame the more difficult topics.

Below are three implications for future implementation of TRIS trainings, based on these teams' reflections:

1. **Building common language is a foundational piece of TRIS work.** As also elevated through CCI's previous Resilient Beginnings cohort that ended in 2020, establishing a shared language and consistent understanding of the relationship between trauma and resilience and longer-term health is foundational to becoming a healing organization. In both Resilient Beginnings initiatives, this foundational work occurred through clinic or organizational training.

2. **Implementation should prioritize and support the discussion aspect of TRIS training.** RBN teams emphasized that it was the discussion that followed training modules that was the most valuable, allowing them to reflect on and process concepts, and identify ways to apply practices in their daily interactions. The opportunity to build relationships and connect also reinforces the TRIS principle of collaboration: learning about the work of colleagues, understanding the stress response of team members, and creating an accountability community.

3. **Training alone is not sufficient to cultivate a trauma- and resilience-informed organization.** Teams that completed the roll out of TRIS training recognized the need to reinforce and deepen the knowledge of individuals and care teams after training ended. They also sought to make ongoing connections between the training and other work related to trauma- and resilience-informed systems occurring in their clinic or organization. Providing TRIS training to new staff was one way to help embed TRIS concepts into the clinic / organizational culture beyond the initial training. Reinforcing TRIS concepts after training will require intentionality and stamina to sustain in clinic environments that have many priorities competing for time and attention.

CCI and CCHE will continue to learn from these teams and any additional teams who opt in to TRIS training in Year 3.

The **CENTER FOR COMMUNITY HEALTH AND EVALUATION**
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