Developing a Trauma- and Resilience-Focused Accountable Community for Health
Considerations for a Comprehensive Approach

AUTHORED BY:

Jeremy Cantor, MPH
Robin Haller, MS

There is increasing awareness of the interplay between an individual's socioeconomic and environmental circumstances and their health. This is in large part due to a growing body of evidence that indicates that the social, economic, and physical environments where people live, work, learn, and age (commonly referred to as social determinants of health) heavily influence health outcomes.[1,2,3]

The experience of trauma is one of the most crucial factors shaping health. The immediate impact of trauma is often acute physical harm; trauma is the leading cause of death among people under the age of 45 in the US.[4] Less noted, however, is that the resulting stress, particularly from repeated exposure to trauma, can negatively and severely impact mental and physical health across the lifespan.[5,6]

Addressing social determinants of health and exposures such as trauma has largely been considered the purview of policymakers and non-health sectors (e.g., housing, law enforcement, social services, education, etc.). However, a number of initiatives are emerging that focus on aligning strategies and resources to create the multi-sectoral and multi-strategy approaches necessary to address complex health issues. Accountable Communities for Health (ACH) are among the most ambitious of these new initiatives, with broad strategy portfolios, diverse partnerships, and aspirations of sustainability.

To explore the potential of multi-sector initiatives to address trauma and increase resilience at a community scale, JSI conducted a scan of current research and led small group and individual conversations with key informants. In this brief, we describe the ways in which trauma affects health, the potential of an ACH approach, and key considerations for the design and implementation of ACH-type initiatives focused on trauma and resilience.

Why focus on trauma?

There is well-established evidence of the direct and cumulative effect of trauma on behavioral and physical health, both at the individual and community level.[5,8,9] Though often associated with the immediate harm to survivors of physical violence, trauma encompasses the effects of a broader range of experiences over a longer timeframe.[10,11,12] Directly experiencing physical violence can lead to trauma, but so can witnessing violence; being exposed to discrimination, racism, poverty, sexual abuse, emotional abuse or neglect; and a range of other emotionally painful experiences.[13] See "Types of Trauma" on the following page for more detail on categories and sources of trauma.

Exposure to traumatic events is strongly linked to:

- Chronic diseases including diabetes, heart disease, high blood pressure, and chronic lung disease.[14,15]

- Hormonal changes, which can put the body in a hyper-aroused stress-response state and lead to sleep disturbances, muscle tension, and a lower threshold for startle responses.[5] The results of this hyperarousal are similar to the effects of post-traumatic stress disorder (PTSD).[5]

The effects of trauma on children can be particularly pronounced and long-lasting. Prolonged exposure to adversity without a mitigating adult presence leads to toxic stress, which in turn has been demonstrated to affect brain development.[16] Adverse Childhood Experiences (ACEs)—including physical, sexual, or emotional abuse; having an alcohol or drug abuser in the household; having a household member who is incarcerated, chronically depressed, mentally ill, or suicidal; having a mother who was treated violently; having one or no parents; and emotional or physical neglect—have been shown to have a dose-response relationship: the number of ACEs experienced in childhood, and the age at which they are experienced, are directly correlated with adverse health risk behaviors (e.g., smoking, alcoholism, drug use) and negative and chronic health outcomes (obesity, depression, diabetes, heart disease, stroke, COPD) later in life.[20]

Even though trauma is increasingly viewed as a public health epidemic, and recognized as having adverse effects at the individual and community level, the strategies for

"Nothing is more damaging to communities than the shadow of violence."

—Loretta Lynch, US Attorney General [7]

addressing trauma are largely focused at the individual level, partly due to the complexity of the problem when viewed from a broader context. While it is important to respond to individuals who have experienced trauma through individual-level approaches such as trauma-informed care, broader structural-level exposures, such as community disconnectedness and inequitable economic opportunity, and root causes of trauma, such as poverty, violence, and racism, also need to be addressed at a community or population level to bridge treatment and prevention.[17,21] Healthcare often serves as a portal of entry for traumatized individuals, and has a unique opportunity to capture and respond to the effects of trauma. Given its resources and authority, the healthcare sector, in partnership with other sectors, can lead the charge in addressing upstream, population-wide causes of trauma, and systematically increase resilience.

Why incorporate resilience?

Research has consistently shown that when the right supports are in place, the majority of young people who grow up amidst extremely challenging circumstances not only survive but end up as thriving adults.[22] Similarly, there are specific factors that have been demonstrated to be protective against traumatic experiences.[23] That ability to "bounce back" has been termed resilience and is investigated at both an individual and community level.[17]

From the perspective of an ACH, the concept of resilience can provide a useful bridge between treatment and prevention strategies, as increasing resilience has positive impacts upstream and downstream. While it is beyond the scope of this brief to synthesize the extensive resilience research or make recommendations for specific strategies, resilience is discussed in the following pages as a vital complement to trauma in terms of framing, strategies, measurement, and partnership development.

Types of Trauma

As a complex physical and psychological phenomenon, there are many ways to categorize and describe sources of trauma. Here is a synthesized list of categories of trauma that may be relevant to ACH initiatives:

Individual Trauma

An individual may experience trauma due to actions taken directly toward them, or by witnessing violent or traumatic incidents experienced by others. These actions can include sexual abuse or assault, physical abuse or assault, emotional abuse or neglect, domestic or interpersonal violence, or bullying.

Community Violence and Community Trauma

Community violence includes gang-related violence, interracial violence, altercations with police, and other forms of group violence.[11] Individuals experience this type of violence as victims, witnesses, or perpetrators. Community violence negatively affects the social networks and connections in a community, and breaks down the structures that might otherwise support resilience and promote healing.[13,17] This can lead to continued violence, perpetuating the cycle of community trauma.

Structural Violence

Community violence is often the result of structural violence, the systematic ways in which embedded social structures disadvantage individuals.[18] Racism, sexism, poverty, institutional bias, and power dynamics are all examples of structures that harm or disadvantage communities or groups of people.[13] These structures create inequalities that lead to victimization and prevent groups of individuals and communities from meeting their basic needs, leading to trauma at the individual and community level.

Complex or Synergistic Trauma

Because of the cyclical nature of trauma, many individuals experience simultaneous or sequential exposure to multiple or chronic traumatic events or experiences. This kind of trauma compounds the difficulty of addressing the source of trauma and its effects, and contributes to a deepened sense of powerlessness to escape or heal.

Historical or Collective Trauma

Historical or collective trauma is the psychological effect of traumatic events experienced by an entire group or society.[19] These events, like war, genocide, slavery, terrorism, or natural disasters, can result in collective grief and anger, and their impacts can be carried across generations within a community. Though some of the physical and emotional effects of collective trauma and community trauma can be similar at an individual level, their root causes are different and require unique approaches for healing.

Retraumatizing Systems

In some cases, the health and welfare systems intended to help individuals can actually further traumatize them. For example, a child's removal from their home, separation from their siblings, and foster home placements can exacerbate the trauma they have already experienced. Coercive or forced treatment or disclosure, confusing or inadequate access to services, or skeptical or unsympathetic responses can reinforce experiences of threat, shame, and powerlessness.[11]

Why adopt an Accountable Communities for Health approach?

Accountable Communities for Health (ACH) has emerged as a leading-edge strategy for thinking broadly about comprehensive health improvement efforts at a geographic scale.[25,26,27] A number of states, including Washington, Minnesota, and Vermont, have launched ACH initiatives as part of federally funded innovation grants. In California, a consortium of funders has pooled resources to support six California Accountable Communities for Health Initiative (CACHI) sites.[25]

According to the California ACH workgroup, an ACH is "a multi-payer, multi-sector alliance of the major healthcare systems, providers, and health plans, along with public health, key community and social services organizations, schools, and other partners serving a particular geographic area. An ACH is responsible for improving the health of the entire community, with particular attention to achieving greater health equity among its residents."[28] CACHI efforts will aim to more efficiently use resources and develop sustainable funding mechanisms for prevention and system-wide population health efforts.

An ACH creates a venue for engaging multiple sectors in the effort to improve the health of a population or community (examples of how varied sectors can be engaged are included in Appendix B). While the ACH model is an emerging approach, research in support of such initiatives and examples from across the country provide insights that can be applied to infrastructure and strategy development.[29,30,31] Drawing on these insights and experiences, below are key questions and considerations for the development of a trauma- and resilience-focused ACH.

Key Considerations for ACH Development

The remaining sections of this brief are intended to serve as guidance for those considering the development and implementation of an ACH focused on trauma and resilience. Every ACH will be tailored to its own community setting. The questions and examples below are not meant to be prescriptive, but rather should serve as a starting point for discussions and initial planning amongst the leaders of potential ACH efforts.

What is the focus and how is it communicated?

There are many possible entry points through which to address sources of trauma. Identifying a clear focus for a trauma-informed ACH will be key to its success: partners need to know what they are joining, and strategies and measures of success must be selected that clearly connect to the focus. It can be valuable to review existing data in order to assess the sources and types of trauma in the community, find opportunities for building resilience, and identify where costs are accruing and where savings and health improvements may be possible.

- **Balance bold vision with practicality:** Focusing on a single cause of trauma (e.g., domestic violence, gang violence) or resilience factor (e.g., cross-age relationships) may narrow the potential partners and the breadth of impact. On the other hand, focusing too broadly can make it difficult to identify coherent strategies and action. As is the case with all health initiatives, "vision without action is a daydream; action without vision is a nightmare."[32]

Given the structures and goals of an ACH, and the complexities and breadth of trauma, there are a number of key questions that should be considered in selecting a focus:

- Is the focus a priority for key stakeholders?
- Are there potential short- and long-term outcomes related to the focus that are easy to measure and reflect significant change?
- Does the focus exclude or stigmatize any groups or populations?
- Are partners evident who will coalesce around the selected focus?
- Does the focus lend itself to a portfolio of strategies that spans upstream, downstream, treatment, and prevention?
- Is there evidence supporting interventions within the focus area?

Using those questions as a guide, Table 1 provides a sample of advantages and considerations, or pros and cons, of possible ACH focus areas.

FOCUS

☐ Balance vision with practicality

☐ Determine what language will be used to communicate with different audiences

☐ Highlight connection to health equity

Table 1. Considerations for potential ACH focus areas

Focus	Advantages	Considerations
Adverse childhood experiences (ACEs)	■ Defined population simplifies approach and activities ■ Clear set of potential partners with shared motivations and understanding ■ Research base is expanding ■ Long-term, cross-generational impact; resilience-building	■ Short-term outcomes may be hard to capture, making early momentum a potential challenge ■ May exclude some types of trauma/populations
Domestic violence and sexual assault	■ Clear set of potential partners with shared motivations and understanding ■ Focused short-term need with possible short-term positive impacts	■ Can be hidden/challenging to identify ■ Preventative work may be long-term due to entrenched norms
Gang violence	■ Positive outcomes beyond health (education, justice, economic opportunity) ■ Contribute to general community safety	■ Challenging to identify victims and perpetrators of gang violence ■ Potentially divisive and stigmatizing
Reducing trauma (no sub-focus)	■ Inclusive of all types of trauma ■ Broad potential impact, not focused on one specific population	■ Difficult to create focused, cohesive portfolio of activities ■ Potentially stigmatizing
Structural violence (poverty, racism, economic opportunity)	■ Lasting, deep impacts through systemic change ■ Truly upstream and preventative	■ Does not focus on existing trauma ■ Complex, tough to tackle problems

■ **Identify common language:** Language and communication will impact the ways in which stakeholders and participants engage with an initiative. For example, focusing on "exposure to trauma" has the potential to stigmatize individuals who have certain experiences, as opposed to "building resilience," which is a more positive frame that could motivate authentic healing. However, "resilience" may need to be contextualized with specific strategies and experiences of personal and historical trauma in order to resonate. What language will generate understanding of the initiative's intent and motivate participation?

■ **Connect the focus to health equity:** An ACH may be able to balance multiple interests by consistently describing how the effort connects to a range of concepts, existing efforts, and outcomes. Specifically, connecting the ACH to health equity efforts will help engage stakeholders and ensure that underserved populations are reached. ACHs should be consistent in describing their efforts to improve health equity in order to make the scope clear, move beyond a focus on individuals to policy and systems change, ensure that the most vulnerable populations are being positively impacted, and activate social justice constituents.[33] Figure 1 illustrates the difference between equality and equity and the value of an equity approach in terms of fair and just outcomes.[34]
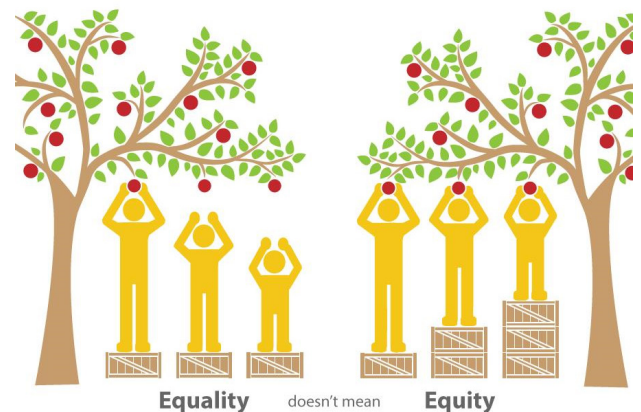

Figure 1. Equality vs. equity[34]

- **Identify champions:** Motivated, inspiring leaders can be instrumental in communicating a vision and focus that will garner support from stakeholders and community members. Physicians and local elected officials can serve as visible, authoritative supporters to raise awareness of the need for action and elevate the issue as a priority. Local community leaders can motivate participation and lend credibility to a potentially hard-to-grasp initiative. Survivors of trauma can be motivating champions by lending a sense of emotion and legitimacy to the problem and the vision for the initiative.

How can authentic community engagement be instilled from the beginning?

The causes and drivers of community trauma are unique to each community, neighborhood, or city, and a one-size-fits-all approach is not likely to be successful. Truly engaging communities from the outset can help ensure that an ACH initiative is well-suited for local realities and can empower community members with a sense of self-efficacy and a feeling that change is possible. This empowerment in itself can be a first step toward building resilience and breaking the cycle of trauma.

Programs that are already in place are a logical place to begin engagement efforts. Who is already doing this work? In particular, it is critical to engage with indigenous, community-initiated healing strategies. These can include, for instance, faith-based activities, healing circles, movement and arts groups, and efforts to create safe spaces for youth. Engaging leaders of these efforts can: build trust through demonstrated respect for the range of responses to trauma (beyond treatment); communicate a desire for inclusiveness; coordinate existing efforts; and identify gaps that might be filled by new ACH activities.

Representatives from the community should be included in planning discussions and governance committees from the start. This ensures that the community has a voice in the development of the ACH priorities, and gives community members the opportunity to provide context for data and reports and act as liaisons to encourage participation. The champions of an ACH initiative or groups involved in existing programs can be helpful in identifying key community members to engage in the initiative. Particular

COMMUNITY ENGAGEMENT

☐ Identify community members that can be included in ACH planning and governance committees

☐ Engage community-initiated resilience and healing strategies

☐ Identify gaps in existing activity

attention should be paid to engagement of survivors of trauma and their families and those involved in community-based healing and resilience work.

What outcomes are intended to change?

Once a focus and vision have been developed, intended outcomes should be identified to provide direction for the activities of the ACH. In many cases there may be an iterative process in which the focus and outcomes are refined in sequence to ensure alignment and stakeholder approval. The outcome selection process should answer two primary questions:

- What are the specific improvements the initiative aims to achieve?

- How will progress or success be measured?

Some outcomes may be captured by indicators that are directly health-related, such as hospitalizations for injuries, while others might include non-health indicators such as high school graduation rates. It is important to consider the timeframe for expected changes to occur, and have a

OUTCOMES

☐ Identify specific improvements that are achievable through the ACH

☐ Determine how progress will be measured and timelines for outcomes

☐ Identify existing data sources and determine what data can be collected with ACH resources

mix of short-term and long-term indicators. Improvements in short-term indicators can help generate momentum and bring in additional resources, while long-term indicators may relate to deeper, sustained change. Availability of resources, the local context, and the trajectory of progress already being made can help determine the appropriate proportion of short- and long-term outcomes. In addition to outcome indicators, it can be valuable to establish process indicators to assess the development of the initiative. A range of sample indicators for a trauma-focused ACH are included in Table 2 below.

When considering outcomes and associated indicator selection, some key questions to ask are:

- What is already being tracked by local agencies and organizations?

- Will data be available in a timely manner to assess progress?

- Are there outcomes that are priorities for specific stakeholders, such as healthcare leaders or local elected officials?

- Who has the resources and capacity to manage, compile, and analyze data?

- What data use agreements might be put in place, and who will facilitate their development?

Table 2. Potential trauma-related indicators

	Short-term Indicators	Long-term Indicators
Health-specific	- Firearm injuries and deaths - Substance use - Hospitalizations for assault injuries - Domestic violence - Child maltreatment - Sexually transmitted infections - Homicide related to gang violence	- Life expectancy - Quality of life - Chronic disease prevalence - Depression/anxiety/mental health - Utilization of healthcare and behavioral health services
Other sectors	- Truancy, suspension, and graduation rates - School safety - Violent crimes - Violent crimes near parks/schools/open spaces - Displacement or homelessness	- Healthy masculinity and gender equity - Perceived safety - Civic engagement and social connectedness - Incarceration - Firearm ownership - Juvenile felony arrests - Access to safe public green space
Process	- Participating sectors represented on leadership team - Sources of funding identified - Meetings held for leadership team - Data sources identified - Participation from local community	- Sustainable funding sources cultivated - Awareness/visibility of initiative - Cost savings - Sense of inclusion among diverse stakeholders and community - Trust in community institutions

What does a comprehensive strategy look like?

A comprehensive ACH portfolio includes strategies across five categories:[35]

Clinical
Health system interventions to more effectively deliver quality services and treatment with a focus on prevention.

Social Services and Community Resources
Programs that provide support to patients and community members. These can be based in governmental agencies, schools, worksites, or community-based organizations.

Clinical-Community Linkage
Mechanisms to connect the clinical care setting to social services, community resources, and policy, systems, and environment change efforts.

Policy and Systems
Legal, regulatory, and system-level changes to reduce barriers and improve access to health for individuals and communities.

Environments
Improvements in social and physical environments to make healthy behaviors easier and reduce harmful exposures for individuals in the community.

The goal in developing a portfolio of strategies is not to create a laundry list of disconnected activities, but rather a balanced, mutually supportive approach that is an integrated response to a complex set of factors.[36] Focusing on one end of the portfolio alone is unlikely to create broad change at a population scale, or to achieve what some have termed adequate "dose."[37] A portfolio that is too heavily weighted toward the clinical end of the spectrum will neither build resilience nor address the root causes or most impactful factors, resulting in continued health inequities. A singular focus on policy initiatives, however, will not respond to the needs of populations that have already experienced trauma or leverage efforts to instill trauma-informed care practices, and may lack short-term, measurable outcomes.

PORTFOLIO OF STRATEGIES

☐ Develop strategies across five portfolio categories, including both treatment and prevention strategies

☐ Strive for alignment and integration of strategies

☐ Engage behavioral health

Refining a portfolio toward coherence and synergy requires iteration and careful consideration of a number of factors. Table 3 includes potential strategies in each category for a trauma-focused ACH. However, no initiative should be considering this many strategies or simply selecting them from a list. The critical questions are:

- What is currently in place that can be leveraged?

- How do the strategies line up with the vision and metrics?

- Is there a team of actors who will carry out the strategies in partnership?

- Is there room for a phased approach wherein certain strategies are implemented first in order to maximize the probability of short-term impact and traction among stakeholders (proof of concept)?

- How do the strategies relate to each other? For instance, if economic opportunity is identified as a key factor in patterns of trauma, then strategies in multiple categories should align to increase economic opportunity.

Due to the impacts of trauma on mental health and substance use, it is particularly important that a trauma-focused ACH engage behavioral health departments and professionals, and raise awareness of trauma-related needs in the behavioral health sector. The engagement of this sector is essential to building resilience in individuals and communities. Due to the cyclical nature of trauma and its effects, ACH developers should consider identifying strategies across the spectrum that have the potential to break the cycle within families and communities. Importantly, these strategies can create a feedback loop; prevention of trauma will limit the need for treatment, and treatment for the impacts of exposure to trauma may reduce future trauma exposure for the individual and their immediate community.

Table 3. Sample portfolio strategies

Within each portfolio category, there are strategies that are aimed at the prevention of trauma (P), and strategies that focus on treating the effects of trauma (T). Labeling strategies as either P or T provides more nuance to the portfolio: everything at the clinical end is not necessarily treatment (T), and policy interventions are not only preventative. This approach can result in more alignment of strategies across categories and overall balance between upstream and downstream focus.

		Strategies	Indicators
Clinical	**P**	■ Provider training on trauma prevention ■ Parent education to prevent ACEs	■ Utilization of services ■ Patient satisfaction ■ Cultural relevance ■ Access to pre-, peri-, and post-natal care ■ Birth outcomes
	T	■ Motivational interviewing/empathy training ■ Provision of trauma-informed care (TIC) ■ Assessment of TIC capacity, support for staff with experiences of trauma ■ Screening for ACEs, trauma	
Social Services and Community Resources	**P**	■ Educational/employment support ■ Healthy masculinity education for men ■ Gang intervention programs ■ WIC/SNAP educating workforce on trauma ■ Faith-based networks to support community building	■ Education attainment ■ Unemployment levels ■ Substance abuse prevalence
	T	■ Community-based mental health and substance abuse programs ■ Post-prison support ■ Engagement of culturally appropriate healing strategies	
Clinical-Community Linkage	**P**	■ Cross-sector (healthcare, behavioral health, social service, criminal justice, etc.) data platform ■ Universal education on impact of violence and its impact on parenting ■ Violence prevention campaigns ■ Violence prevention programs in schools	■ Formalized systems for linkage (data sharing) ■ Student awareness of violence prevention
	T	■ Case conferences: Strong referral network ■ Training of non-traditional "providers" ■ School-based services	
Policy and Systems	**P**	■ Funding for transitional housing ■ Family-support platform ■ Living wage policy, disrupt intergenerational poverty ■ Joint use agreements to expand greenspace ■ Criminal justice reform ■ Review of public policy through lens of systemic racism and bias	■ Confidence in criminal justice and policy ■ Sense of political efficacy
	T	■ Infusing trauma-informed practices across systems ■ Restorative justice	
Environments	**P**	■ "Community safety by design" environmental safety programs ■ Reclaiming community spaces ■ Regular opportunities for community interaction and connection ■ Education and economic opportunity for disadvantaged groups	■ Investments in neighborhood ■ Presence of businesses and job opportunities ■ Sense of social efficacy ■ Safe spaces, maintained physical environment
	T	■ Relationship between police and community; trauma-informed policing	

How can a cross-sector collaborative be built to oversee and implement the initiative?

Identifying goals and outcomes that benefit all stakeholders in some way, developing agreements that detail roles and responsibilities, and involving key stakeholders and sectors in the development and vision-setting process can foster feelings of ownership and motivate engagement. In order to organize and coordinate participating groups and agencies, a leadership structure and decision-making process must be identified that clarifies:

- Who will be in leadership roles?
- How will questions or decisions be resolved?

A "backbone" organization should be identified that will be responsible for convening and facilitating the governing committee. In the case of a trauma-focused ACH, a two-tier governance structure may make the most sense (see Figure 2):

- A governing committee (indicated in Figure 2 by the larger circles) made up of representatives who are selected to oversee the initiative based on criteria

such as having invested resources in the ACH, specific vital capacities, existing programs, community credibility, or political clout. Each member of the governing committee may provide input on core ACH elements such as funding, strategy development, partner engagement, and data sharing.

- An advisory committee whose members (indicated in Figure 2 by the smaller circles) would not have decision-making power but would provide valuable input on the process and portfolio activities, and may be involved in implementation of strategies.
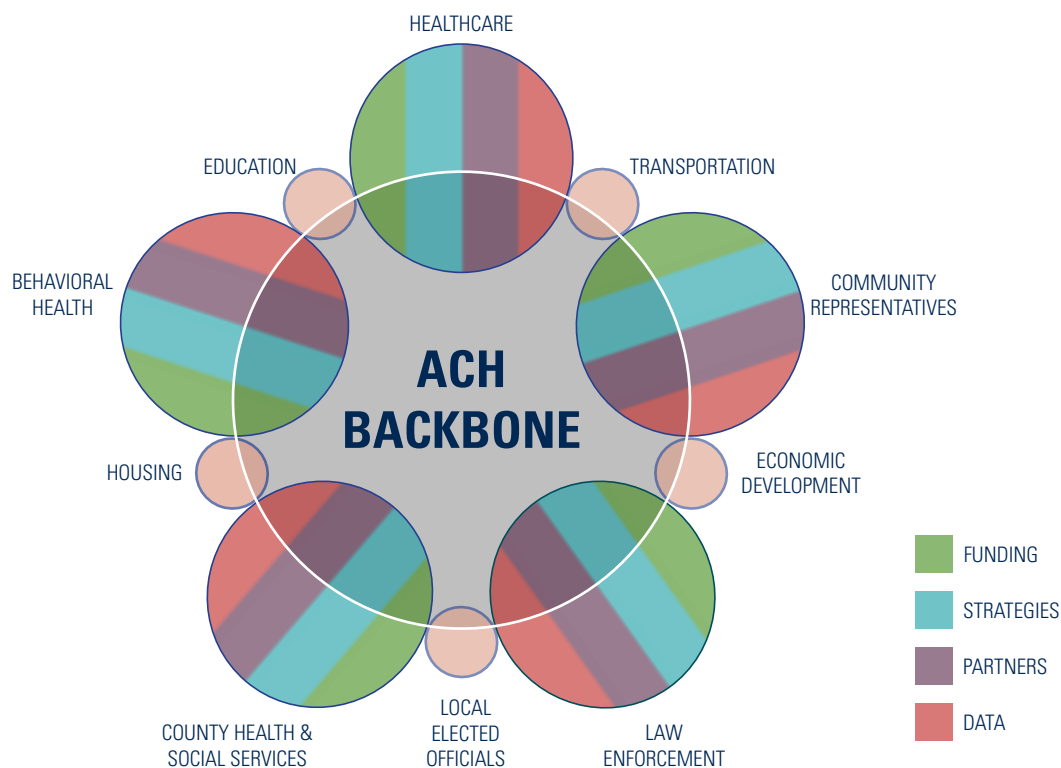

Figure 2. Sample two-tiered governance structure

Legend:
- FUNDING
- STRATEGIES
- PARTNERS
- DATA

What is the plan for sustainability?

In order to achieve an ambitious agenda, a trauma-focused ACH will likely need to be active for a substantial amount of time. Given that most current initiatives are supported by a few years of grant funding, the issue of sustainability is paramount. The first sustainability question for any enterprise is, "What is the clear value proposition?" The value proposition should explain:

- The scope of issue (why is this compelling and important?)

- A defined solution (what will the response look like?)

- The expected benefits (who will benefit and how much?)

The solution may be described initially as a participatory process given that the portfolio of strategies will be developed by stakeholders. The expected benefits may be financial returns to multiple sectors or other non-financial benefits including health improvements and enhanced reputation.

A few considerations in planning for sustainability include:

- There are different categories of funding, and the mix of funding will evolve over time.

  - Voluntary: Funds provided prospectively at the discretion of the funder or payer

  - Contingent: Funds provided if an ACH achieves agreed upon milestones

  - Mandatory/Automatic: Funds allocated to the ACH through a predictable, required mechanism[38]

- Pursue braiding and blending of funds.* With a focus on trauma, it is important to investigate funding in other sectors such as education, criminal justice, and housing to uncover funds that are related either in terms of purpose or the individuals that are intended to benefit. One of the functions of an ACH can be to help potential funders see how their resources will be leveraged, drawing other resources toward the same priority. Figure 3 depicts the ability of an ACH to create a "center of gravity" influencing a range of decisions.

- Encourage shared investment, even in small amounts, from the outset. Partnerships and collective will are enhanced when there some sense of shared "skin in the game." A "wellness fund" is a mechanism used by many ACH initiatives to encourage and manage shared investment through pooled funds. Shared investment also becomes a key selling point in promoting the initiative to stakeholders, potential partners, and future funders.

SUSTAINABILITY

☐ Clarify the unique value proposition of the ACH

☐ Identify multiple types of funding

☐ Encourage shared investment, even if small amounts

Figure 3. Center of Gravity: an ACH can influence a range of decisions to align with its goals

---
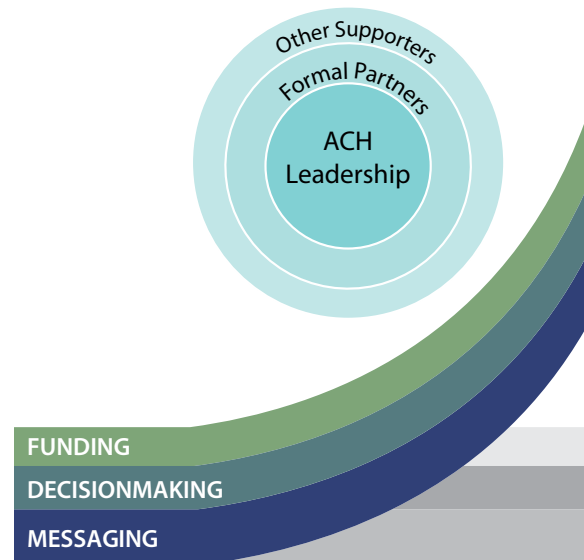
* Braiding funds means aligning existing funding streams to pay for services, projects, or infrastructure that could not be supported by any single stream while maintaining separate accounting for spending and outcomes by stream. Blending funds means putting resources in a collective "pool" from which they are generally spent based on the judgment of a governing body that manages that pool without tracking specific spending to specific sources.

Conclusion

The growing interest in and support for ACH initiatives across the country provides a unique opportunity to address trauma and promote resilience for individuals and communities. A successful ACH will include well-coordinated, synergistic strategies across all five portfolio categories, will make community engagement and cross-sectoral collaboration a priority, and will have well-defined indicators of success. The ACH focus on both upstream and downstream strategies is well-suited to address the cyclical nature of trauma and its impacts on physical, mental, and community health. The approaches outlined above are intended to serve as a starting point for the development and implementation of trauma- and resilience-focused ACH initiatives across the country.

"The scope of the issue is huge—it's massive. It's a public health crisis. And it's been a largely unrecognized public health crisis, the link between trauma and health."

—Nadine Burke-Harris, MD
Founder of the Center for Youth Wellness[24]

Appendix A
Trauma- and Resilience-Focused ACH Development Checklist

FOCUS

☐ Balance vision with practicality

☐ Determine what language will be used to communicate with different audiences

☐ Highlight connection to health equity

COMMUNITY ENGAGEMENT

☐ Identify community members that can be included in ACH planning and governance committees

☐ Engage community-initiated resilience and healing strategies

☐ Identify gaps in existing activity

OUTCOMES

☐ Identify specific improvements that are achievable through the ACH

☐ Determine how progress will be measured and timelines for outcomes

☐ Identify existing data sources and determine what data can be collected with ACH resources

PORTFOLIO OF STRATEGIES

☐ Develop strategies across five portfolio categories, including both treatment and prevention strategies

☐ Strive for alignment and integration of strategies

☐ Engage behavioral health

CROSS-SECTOR COLLABORATION

☐ Identify shared goals and outcomes that benefit and motivate all stakeholders

☐ Identify lead organization and governing committee members, including members from across sectors

☐ Develop teaming agreements, including commitments to share data

SUSTAINABILITY

☐ Clarify the unique value proposition of the ACH

☐ Identify multiple types of funding

☐ Encourage shared investment, even if small amounts

Appendix B
Relevant Practice Examples

As discussed in this brief, Accountable Communities for Health is an emerging and ambitious approach to addressing health priorities at a geographic scale. As a result, the first wave of ACH sites will provide a testing ground and will be monitored closely for replicable practices and successes. However, there are examples from across the country of multi-sector initiatives focused on trauma that lay out some of the foundation for ACH approaches to build on. Below are short descriptions of a handful of interesting and inspiring examples.

St. Louis Regional Youth Violence Prevention (YVP) Task Force[39]

In 2012, in response to high rates of youth gun violence and gun deaths, Mayor Francis Slay formed the St. Louis Regional Youth Violence Prevention (YVP) Task Force. The Task Force brought together service providers, youth, municipal officials, educators, faith-based leaders, funders, law enforcement personnel, and community members to develop a regional plan for improving safety and preventing youth violence. Through community forums, the Task Force identified prevention, intervention, enforcement, and re-entry strategies, including job training for youth; expanded access to programs that build resiliency and offer mental and behavioral health support; and improved accessibility to safe spaces for youth, strengthening collaboration between law enforcement and the community and reducing youth access to weapons. The stakeholders in the YVP Task Force work together to identify resources, including national, state, and local funding sources, engage affected communities, execute strategies, and champion policy change.

Family Policy Council, Washington State[40,41]

The Family Policy Council in Washington State worked for almost 20 years in the 1990s and early 2000s to address youth violence in the state. The Council supported counties statewide in establishing community networks to implement cross-sectoral initiatives. By involving the people most affected by problems, these community-based initiatives were able to improve graduation rates, reduce youth violence, and reduce intimate partner violence. The communities established shared goals, created coalitions, learned how to use data and bring in resources. The work is now being supported through the Washington State ACEs Public-Private Initiative, which is using evidence-based models to better understand how communities can prevent and reduce adverse childhood experiences. The stakeholders involved in the initiative include representatives from the Department of Health, the Department of Social and Health Services, other local government agencies, private foundations, state government offices, and community members. They are also working to evaluate and expand the evidence base around community-based, population-level ACEs initiatives.

Greater Louisville Project[42]

When Louisville merged with surrounding Jefferson County in 2003, local leaders felt the need to bring communities together, reduce disparities, and improve development in urban communities, which were behind the surrounding suburbs on many measures of health and well-being. Thirteen local foundations came together to create the Greater Louisville Project, aimed at improving education, jobs, and overall quality of life. This led to cross-sector partnerships focused on higher education, health, and violence prevention, all of which are using data and statistics to identify and resolve inequities. The Bold Goal initiative, for example, uses data from insurance claims, the Robert Wood Johnson Foundation's social determinants of health framework, focus groups with community members, and a town hall meeting in an effort to make the city 20 percent healthier by 2020. Using this data and knowledge of the impact of environment on health, collaborators may use resources to plant trees in areas with high asthma rates rather than providing inhalers to those suffering from asthma.

Peace4Tarpon Initiative, Tarpon Springs, Florida[43]

With the birth of the Peace4Tarpon initiative in 2011, Tarpon Springs became the first city in the country to declare itself a "trauma-informed community." The community has made a commitment to engage stakeholders from across sectors in the shared goals of understanding the effects of adversity on the community and instituting resilience-building practices to reduce trauma. The initiative gained traction through early support from the mayor and board of commissioners, who brought together a 30-person steering committee with representatives from law enforcement, local government, churches, the community health center, schools, welfare, and community members. They developed and signed a memorandum of understanding, and have formed five subcommittees (community action, health and wellness, education, children's initiative, and social marketing) which meet regularly to move the initiative forward. Among other activities, the initiative has helped implement trauma-informed grand rounds for physicians, and has led to the inclusion of the provision of trauma-informed information to all county health facilities as a goal in the Community Health Improvement Plan. The work of the initiative has been carried out without support from a large grant; the initiative's success has been attributed, in part, to the "ground-up" nature of its growth.

Blueprint for a Safer Philadelphia[44]

The Blueprint for a Safer Philadelphia Initiative was created by State Representative Dwight Evans through his efforts to secure $16 million dollars in state funding for youth violence prevention. The plan for the 10-year community-based initiative was written with input from lawmakers, law enforcement officials, public health officials, community leaders, and over 300 youth, and aims to leverage resources, expertise, and capacity of a wide range of stakeholders. The two strategy groups—the Management Team and the Strategic Advisory Committee—include members from across sectors and meet bi-weekly to manage the program directions, strategy, implementation, and outcome measurement. Some of the initiative's activities include targeted social media campaigns, community forums, and a referral hotline to provide youth and families with access to resources. The Blueprint also benefits from a Think Tank, composed of experts in public health, youth violence programs, education, and substance abuse, which meets quarterly and provides insight on the direction of the initiative.

Appendix C
Key Informants

Ruben Cantu, California Pan-Ethnic Health Network (formerly, now with Prevention Institute)

Mark Cloutier, Center for Youth Wellness

Lucia Corral Peña, Blue Shield of California Foundation

Larissa J. Estes, Prevention Institute

Lisa Fujie Parks, Prevention Institute

Laura Hogan, Futures Without Violence

Lisa James, Futures Without Violence

Jen Leland, Trauma Transformed

Leslie Mikkelsen, Prevention Institute

Elizabeth Morrison, Elizabeth Morrison Training & Consulting

Howard Pinderhughes, UCSF

Mary Rainwater, Independent Consultant

Jodi Ravel, Northern California Community Benefits Programs, Kaiser Permanente

Matthew Reddam, Trauma Transformed

Juan Taizan, California School-Based Health Alliance

Rachel Wick, Blue Shield of California Foundation

References

1. Heiman HJ, Artiga S. *Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity.* Issue Brief [Internet]. June 3, 2016. Available from: http://kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/

2. World Health Organization, Commission on Social Determinants of Health. *Closing the gap in a generation: health equity through action on the social determinants of health.* CSDH final report. Geneva: WHO; 2008.

3. Taylor LA, Coyle CE, Ndumele C, Rogan E, Canavan M, Curry L, & Bradley EH (2015). *The Social Determinants of Health: What Works?* Yale Global Health Leadership Institute, prepared for Blue Cross Blue Shield of Massachusetts Foundation. Accessed October 30, 2015 at: http://bluecrossfoundation.org/sites/default/files/download/publication/Social_Equity_Report_Final.pdf

4. Centers for Disease Control and Prevention. *Ten Leading Causes of Death and Injury.* February 25, 2016. Accessed at: http://www.cdc.gov/injury/wisqars/leadingcauses.html

5. Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment. *Treatment Improvement Protocol (TIP) Series, No. 57. Chapter 3, Understanding the Impact of Trauma.* 2014. Accessible at: http://www.ncbi.nlm.nih.gov/books/NBK207191/

6. Van der Kolk BA et al. (2005). *Disorders of extreme stress: the empirical foundation of a complex adaptation to trauma.* Journal of Traumatic Stress, 2005. 18, 5:389-399.

7. United States Department of Justice. *Attorney General Loretta E. Lynch Delivers Keynote Address at the Urban Institute Economic Mobility Conference*, September 14, 2016. Accessible at: https://www.justice.gov/opa/speech/attorney-general-loretta-e-lynch-delivers-keynote-address-urban-institute-economic

8. Lopez-Martinez A, et al. *Physical Health Consequences of Interpersonal Trauma: A Systematic Review of the Role of Psychological Variables.* Trauma Violence Abuse, July 25, 2016

9. Substance Abuse and Mental Health Services Administration. *Trauma and Violence.* Accessed November 9, 2016 at: http://www.samhsa.gov/trauma-violence

10. Rich JA and Grey CM. *Pathways to Recurrent Trauma Among Young Black Men: Traumatic Stress, Substance Use, and the "Code of the Street."* American Journal of Public Health: May 2005, Vol. 95, No. 5, pp. 816-824. doi: 10.2105/AJPH.2004.044560

11. Substance Abuse and Mental Health Services Administration. *Types of Trauma and Violence.* Accessed November 9, 2016 at http://www.samhsa.gov/trauma-violence/types

12. The National Child Traumatic Stress Network. *Types of Traumatic Stress.* Accessed November 9, 2016 at http://www.nctsn.org/trauma-types

13. Pinderhughes H. *Making the Case: Addressing and Preventing Trauma at the Community Level.* November 2013. Available at: https://www.preventioninstitute.org/publications/addressing-and-preventing-trauma-community-level

14. Scott KM et al. *Associations between Lifetime Traumatic Events and Subsequent Chronic Physical Conditions: A Cross-National, Cross-Sectional Study.* 2013. PLoS ONE 8(11): e80573. doi:10.1371/journal.pone.0080573

15. Center for Youth Wellness. *An Unhealthy Dose of Stress.* Accessible at: http://www.centerforyouthwellness.org/download/document/203/CYW%20White%20Paper_An%20Unhealthy%20Dose%20of%20Stress_National%20Final.pdf

16. Center for Youth Wellness. *A Hidden Crisis: Findings on Adverse Childhood Experiences in California.* Available at: https://app.box.com/s/nf7lw36bjjr5kdfx4ct9

17. Davis R, Pinderhughes H, Williams M. *Adverse Community Experiences and Resilience: A Framework for Addressing and Preventing Community Trauma.* Prevention Institute, February 2016. Available at: https://www.preventioninstitute.org/publications/adverse-community-experiences-and-resilience-framework-addressing-and-preventing

18. Farmer P. *An Anthropology of Structural Violence.* Current Anthropology Vol. 45, No. 3 (June 2004), pp. 305-325

19. Healing Collective Trauma. *What is Collective Trauma?* Accessible at: http://www.healingcollectivetrauma.com/

20. Felitti VJ. *Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study.* Am J Prev Med. 1998 May;14(4):245-58.

21. Trauma Transformed. *Mission and Vision.* Accessed November 9, 2016 at: http://www.t2bayarea.org/about/mission.html

22. Zolkoski SM, Bullock LM. *Resilience in children and youth: A review.* Children and Youth Services Review. 2012 Dec 31;34(12):2295-303.

23. Walsh TB et al. *Promoting protective factors and strengthening resilience.* InAdvances in Child Abuse Prevention Knowledge 2015 (pp. 203-233). Springer International Publishing.

24. California School Boards Association. *A Conversation with Nadine Burke-Harris, MD.* Summer 2013. Accessible at: https://www.csba.org/Newsroom/CASchoolsMagazine/2013/Summer/InThisIssue/2013_SummerCSM_Convo.aspx

25. Community Partners. *California Accountable Communities for Health Initiative.* Accessible at: http://communitypartners.org/cachi

26. Washington State Health Care Authority. *Accountable Communities of Health.* Accessed November 9, 2016 at: http://www.hca.wa.gov/about-hca/healthier-washington/accountable-communities-health-ach

27. Mikkelsen L, Haar WL. *Accountable Communities for Health: Opportunities and Recommendations.* 2015. Prevention Institute. Accessible at: http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/Pop_Health/VT%20ACH%20Opportunities%20and%20Recommendations.pdf

28. The Innovation Plan "ACH" Work Group. *Recommendations for the California State Healthcare Innovation Plan Accountable Communities for Health Initiative.* May 2015. Accessible at: http://www.chhs.ca.gov/InnovationPlan/ACH%20Work%20Group%20Report%20FINAL.pdf

29. Verbitsky-Savitz, N et al. *Preventing and Mitigating the Effects of ACEs by Building Community Capacity and Resilience: APPI Cross-Site Evaluation Findings.* 2016. Washington, DC: Mathematica Policy Research. Accessible at: http://www.appi-wa.org/wp-content/uploads/2016/08/APPI_Final-Report_Full-Report.pdf

30. Kania J and Kramer M. *Embracing Emergence: How Collective Impact Addresses Complexity.* Stanford Social Innovation Review, January 21, 2013. Available at: http://ssir.org/articles/entry/embracing_emergence_how_collective_impact_addresses_complexity

31. *Challenges and Opportunities in Philadelphia.* Accessed November 9, 2016 at: http://www.sanctuaryweb.com/PublicHealth/TowardaTrauma-InformedCityPhiladelphia.aspx

32. Japanese proverb

33. Kania J and Kramer M. *The Equity Imperative in Collective Impact.* Stanford Social Innovation Review, October 6, 2015. Available at: http://ssir.org/articles/entry/the_equity_imperative_in_collective_impact

34. Maine Office of Health Equity. *What is Health Equity?* Accessed November 9, 2016 at http://www.maine.gov/dhhs/mecdc/health-equity/.

35. Community Partners. *CACHI Request for Proposals.* Accessed November 11, 2016 at http://www.communitypartners.org/cachi-rfp.

36. Haar W and Cantor J. *Accountable Communities for Health: A 'Portfolio of Strategies' Approach to Improving Population Health.* Prepared for Blue Shield of California Foundation by Prevention Institute and JSI Research and Training Institute, Inc. February 2016. Available at: http://www.communitypartners.org/sites/default/files/documents/cachi/resources/PI-JSI%20Commentary.pdf

37. Schwartz P et al. *Dose Matters: An Approach to Strengthening Community Health Strategies to Achieve Greater Impact.* Institute of Medicine Discussion Paper; August 26, 2015. Washington, DC. http://nam.edu/wp-content/uploads/2015/08/Perspective_DoseMatters.pdf. Accessed September 2016.

38. Cantor J, Tobey R, Houston K, Greenberg E. *Accountable Communities of Health: Strategies for Financial Sustainability.* JSI Research and Training Institute, Inc. May 2015. Available at: http://www.jsi.com/JSIInternet/Inc/Common/_download_pub.cfm?id=15660&lid=3

39. *Youth Violence Task Force.* October 15, 2013. Available at: https://www.stlouis-mo.gov/government/departments/mayor/news/Youth-Violence-Task-Force.cfm

40. Bornstein D. *How Community Networks Stem Childhood Traumas.* The New York Times, August 17, 2016. Available at: http://www.nytimes.com/2016/08/17/opinion/how-community-networks-stem-childhood-traumas.html?emc=edit_ty_20160817&nl=opinion&nlid=75803311&

41. The Washington State ACEs Public-Private Initiative. *FAQs.* Accessed November 9, 2016 at: http://www.appi-wa.org/about/faqs

42. Robert Wood Johnson Foundation. *Health Equity is their Compass.* Accessed November 9th, 2016 at: http://www.rwjf.org/en/library/collections/coh-prize-winners/2016-winner-louisville-ky.html

43. ACEs Too High. *Tarpon Springs, FL, First Trauma Informed City, Embraces Messy Path Towards Peace.* September 17, 2014. Accessible at: http://acestoohigh.com/2014/09/17/tarponsprings/

44. *Blueprint for a Safer Philadelphia.* http://www.phillyblueprint.com/