KIDS NETWORK / ACEs CONNECTION
September 4, 2019

MINUTES

Attendance: Sarah Adams, Terri Allison, Eulalia Apolinar, Sylvia Barnard, Kelley Barragan, Florene Bednersh, Jennifer Bergquist, Lisa Brabo, Korey Capozza, Holly Carmody, Emily Casarez, Tammie Castillo-Shiffer, Maria Chesley, Jody Colt, Steven DeLira, Peggy Dodds, Ashleigh Erving, Alice Gleghorn, Gabriela Hanson-Lopez, Joan Hartmann, Tanja Heitman, Alma Hernandez, Polly Huffer, Valerie Kissell, Amy Krueger, Seth Miller, Lorraine Neenan, Alexis Nshamamba, Mari Ortega-Garcia, Dean Palius, Taundra Pitchford, Shana Pompa, Mayra Ramos, Andria Ruth, Saul Serrano, Tom Sodergren, Sharol Viker, Alana Walczak

Staff: Barbara Finch and Gloria Munoz

1. **Welcome and Introductions**
   Barbara Finch welcomed everyone and introductions were made.

2. **Approve Minutes: June 5, 2019**
   Lisa Brabo motioned to approve the June 5, 2019 minutes and Lorraine Neenan seconded the motion. Peggy Dodds, Joan Hartmann and Mari Ortega-Garcia abstained from voting; all others voted in favor and the minutes were approved.

3. **Public Comment - Items not on the Agenda**
   There was no public comment.

4. **Weaving Connections**
   Terri Allison asked the members to break into triads and discuss the following: Think of a time when you recognized fragility in a situation… How did you become aware of it? How did you adjust your approach to step lightly? Each person had three minutes to do the sharing process. Folks discussed recognizing when to pull back when helping families and being present with the families and providing them with what they need instead of what they are expected to provide.

5. **Resilient Santa Barbara County: Official Launch**
   - **Community Partner Checklist**
   - **Memorandum of Understanding**
   - **Resources and Support**
   - **ACEs Connection**

   Barbara announced the official launch of the Resilient Santa Barbara County campaign with the distribution of the Resilient Santa Barbara County Toolkit (see attached). The Steering Committee has worked together for about a year and one of the projects that they took on was to create a work group to form a toolkit.

Barbara went over the Toolkit and what it includes (see PPT and folder):

- **Community Partner Checklist**
  Barbara mentioned that they recognized that organizations are going to be in different states of readiness around this and they can do the checklist in any order. She added that signing the MOU has benefits but it does not obligate them to meetings or projects. She encouraged folks to proceed at their own pace in a way that feels comfortable.

- **Memorandum of Understanding (MOU)**
  Members gave feedback about the MOU and suggested modifying the language. Agencies questioned the need to do ACEs screening with everyone and Barbara clarified that this is not the intent, only that agencies promote ACEs awareness. One suggestion was to change the document from an MOU to an Agreement. Clarification on expectations for data sharing was also requested.

- **Resources and Support**
  The toolkit includes Frequently Asked Questions, Definitions, ACEs 101, SAMHSA Trauma Guide, ACEs & Protective Factors Flyers, and additional resources

- **ACEs Connection** www.acesconnection.com Santa Barbara County ACEs Connection community

6. **Pediatric Resiliency Collaborative: Building on the Santa Barbara Resiliency Project**
   Korey Capozza introduced the Pediatric Resiliency Collaborative (PeRC), a Cottage Health initiative. PeRC focuses on the pediatric clinic setting and how clinics can address Adverse Childhood Experiences (ACEs) and promote resiliency in that environment. Cottage also convenes the Behavioral Health Collaborative to address access to behavioral health care across the county. They are in the process of implementing a pilot that is expanding access for children. Pediatricians who want to address behavioral health can consult with child psychiatrists at the Department of Behavioral Wellness.

   Dr. Andria Ruth gave an update on the Santa Barbara Resiliency Project and stated that Santa Barbara Neighborhood Clinics started screening for ACEs in October 2017 in their infant well child visits. They engaged CALM as their therapeutic partner and the University of California Santa Barbara (UCSB) as their evaluator. They developed a very deliberate process with input from members of the community before launching this research project. They have screened almost 200 families and are getting close to their goal of having 100 enrolled. The cut offs that they used to determine eligibility were infants with one ACE, and/or parents with two or more. They offered eligible families the opportunity to participate in the research project. Everyone except one family filled out the ACEs questionnaire. The families appreciated being asked to participate, and almost 80% of the families agreed to participate in the research study when they went for their well child visit. Families were randomly assigned to one of three levels of intervention. After approximately one year, they looked at medical outcomes and information on the child's resilience and development. They are in the process of evaluation and do not have data to report yet, but it has been very well received and positive for everybody. They have had one paper published about the acceptance of the screening and are currently working on another one that describes how the Wellness Navigators connect families to needed services.

   Dr. Peggy Dodds shared an update on the Carpinteria Resiliency Project, which is a partnership between the Public Health Clinic and the Carpinteria Children's Project, the local family resource center (FRC). They are screening at the clinic using the same cutoff criteria as the Neighborhood Clinics so that they can compare findings. If a family screens positive they refer them to the FRC. The Maternal Child Adolescent Health (MCAH) nurses are screening families with newborns during home visits and are also using the same criteria in referring to the FRC. They have created a series of three interventions and handouts that they can give out.

The Pediatric Resiliency Collaborative has looked at what these two clinics have done and asked how they can expand this countywide to every pediatric clinic in the county. They believe that getting to families through the trusted relationship of the pediatrician is a high value approach. They are trying to find a hybrid model between these two clinics so that they can bring this type of screening and referral to many more clinics in a way that is going to be sustainable. One idea is to provide intensive technical assistance for four clinics per a year by utilizing one navigator and one CALM therapist across all four clinics. This will meet the need for in-house co-located services in a way that is less resource-intensive. In addition, they are exploring the process for commercially insured populations. At the end of this experiment, they hope to have a case to make to insurers that this is something that they should pay for. All this work is happening as the state policy landscape is changing. There is a new state mandate to screen MediCal patients for ACEs. Children will be screened annually and adults, once over the course of their lifetime. There is reimbursement and training coming for ACEs screening but not a lot of details about what that will look like. They are pushing ahead but trying to incorporate the shifting policy landscape as they go. Korey thanked the two clinics for being on the vanguard of this movement because it has set us up to be leaders for addressing ACEs in the pediatric clinic setting.

7. Family Service Agency: Trauma-Informed Self-Assessment

Ashleigh Erving and Lisa Brabo, from Family Service Agency (FSA), gave a presentation on the Organizational Self-Assessment for Trauma-Informed Care (see attached). Ashleigh first came across the Guide to Completing the Agency Self-Assessment (see attached) during a Child Abuse Prevention Council (CAPC) meeting in 2015. She mentioned that implementing trauma specific interventions without assessing the agency's trauma-informed care culture is likely to reduce the efficacy of the intervention. The self-assessment has 100 questions and covers five domains: Supporting Staff Development, Staff Supervision, Support and Self-Care, Creating a Safe and Supportive Environment, Assessing and Planning Services, Involving Consumers, and Adapting Policies. When they introduced the tool to their agency staff, they evaluated the agency's practice based on their experience over 12 months. The second tool was the Chadwick Trauma-Informed Systems Dissemination and Implementation Project's "Secondary Traumatic Stress in Child Welfare Practice: Trauma-Informed Guidelines for Organizations." FSA first conducted the survey in 2016, prior to their merger, and again in 2018, post-merger with SMVYFC. There was a 76% completion rate in 2016 and a 77% completion rate in 2018. Lisa went over the following results:

- Definite difference in results by geographic region (Lompoc scored the highest on all)
- Programs comprising direct service staff had a better average response and less "do not know"
- Three areas showed improvement from 2016 to 2018: services and trauma-specific interventions, written policies, and fewer "Areas to Strengthen" listed by staff.

Ashleigh and Lisa offered examples of actions taken in each area based on results:

- **Supporting Staff Development**
- Offered training and education that specifically addresses trauma, safety, crisis intervention, etc. Provided a presentation to their Board of Directors on becoming a trauma-informed organization
- Created a Secondary Traumatic Stress Advisory Committee who meets monthly
- Helped cultivate next steps for FSA Strong, a volunteer based staff committee that promotes wellness activities within the organization to support morale
- Trained their front desk staff on secondary trauma, trauma-informed care, how to recognize what is going on, how to approach it, and how to care for themselves
- **Staff Supervision, Support and Self-Care**
- Made modifications to their facilities to improve safety
- Worked on being creative and mindful of an environment that is really welcoming and appropriate for anyone where they might be within the lifespan

- **Creating a Safe and Supportive Environment**
- Redesigned several of their Family Resource Centers
- Developed a Release of Information Authorization Form and script to support how they are introduced and how they talk about complex topics with consumers
- **Assessing and Planning Services**
- Completed a Strategic Planning Process and included Trauma-Informed Approaches/ Practices
- Enlisted the help of an expert to look at the tools they are using for their mental health assessments so that they can choose additional assessments that are better for working with people's trauma
- Regular training on Motivational Interviewing and consultation services with trainers
- Flexibility in programming
- **Involving Consumers**
- Transitioned to an evidence-based tool that will be used across FSA programs. It is the first time they have identified a tool that can be applicable to so many programs.
- Conducted consumer focus groups to help drive some of the improvements
- **Adapting Policies**
- Looked carefully at all polices to be sure that they have a trauma-informed perspective
- Regularly review their program policies at staff meetings

Lisa concluded by encouraging organizations to choose their Self-Assessment carefully. The analysis of the results is most effective with data expertise. The better you understand the results the better you can respond to the results. She stressed the importance of developing a plan for next steps. This is a continual process and just one way of monitoring what is happening.

8. ACEs Steering Committee Update

Terrie stated that the Toolkit Work Group will continue meeting, working and incorporating the suggestions that were made today. They will be also be combining the other two Work Groups, Coordinating Existing Actions and the Pilot Project.

9. Updates and Announcements

- **Barbara Finch** announced that the KIDS Executive Committee will do a revision of the KIDS Network By-Laws at a future meeting.
- **Steve DeLira** shared that Family Service Agency/Santa Maria Valley Youth and Family Center is having a photo contest. Steve will send out a link with more details.
- **Florene Bednersh** mentioned that the Early Childhood and Family Wellness Coalition will meet on October 10th and will learn about services for homeless children in the prenatal to five range .
- **Kelley Barragan** shared that the Perinatal Wellness Coalition is putting on a conference that will focus on perinatal mental health and fathers. It will be held on June 15, 2020.
- **Alma Hernandez** stated that the community of Guadalupe is working on a Resilient Guadalupe project She suggested inviting them to a KIDS Network meeting.
- **Alice Gleghorn** announced that Ana Vicuna accepted a position with Butte County and that the new Division Chief would be announced soon. She shared that the Family Assistance Center opened in response to the boating disaster and that families, first responders, company personnel have appreciated the support from community organizations and members of the clergy.

10. Meeting Adjourns

Next Meeting – KIDS Network Full Membership, November 6, 2019

The meeting adjourned at 10:58 a.m.

Family Service Agency of Santa Barbara County

Santa Maria Valley Youth and Family Center

Guadalupe Little House by the Park

Organizational Self-Assessment

for Trauma-Informed Care

FSA Organizational Self-Assessment for Trauma-Informed Care

Tools

1.) Agency Self-Assessment for Trauma-Informed Care

2.) Chadwick Trauma-Informed Systems Dissemination and Implementation Project's *"Secondary Traumatic Stress in Child Welfare Practice: Trauma-Informed Guidelines for Organizations"*

FSA has Conducted the Self-Assessment Twice

2016 Pre-Merger

2018 Post-Merger with SMVYFC

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FSA Organizational Self-Assessment for Trauma-Informed Care

A Little Context

FSA 2016: 95 Staff 13,000 Children & Adults Served $6 million budget

FSA 2018: 175 Staff 25,000 Children & Adults Served $11 million budget

FSA Services

Support for Families

Case Management

Parent and Relationship Education

Infant and Early Childhood Home Visits

Mentors/School-Based Outreach Mentors

Behavioral Health

Mental Health Counseling

School-Based Counseling

Youth Substance Abuse Treatment

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FSA Organizational Self-Assessment for Trauma-Informed Care

April 2016 - Pre-Merger

- Could complete via Survey Monkey or hard copy
- Allowed 4 weeks to complete (during staff meetings so could discuss after)
- About 76% completion rate (72 respondents)

October 2018 - Post-Merger with SMVYFC

- Could complete via Survey Monkey only
- Management staff completed first (so familiar with it) – 10 days
- Rest of staff – 2 weeks to complete
- About 77% completion rate (134 respondents)

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FSA Organizational Self-Assessment for Trauma-Informed Care

A Few Notes About Results

- Definite differences in results by geographic region (north, mid and south county)

- Programs comprising direct service staff had a better average response and less “do not know” responses

<u>2016 to 2018 Areas Showing Improvement</u>:

- “Offering Services and Trauma-Specific Interventions”

- “Creating Written Policies”

- Fewer “Areas to Strengthen” Listed by Staff

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FSA Organizational Self-Assessment for Trauma-Informed Care

Example Actions Taken Based on Results

Five Domains

- Supporting Staff Development
- Creating a Safe & Supportive Environment
- Assessing and Planning Services
- Involving Consumers
- Adapting Policies

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FSA Organizational Self-Assessment for Trauma-Informed Care

Considerations

- Is this the right tool for your organization at this time?

- Analysis of results is most effective with data expertise

- Development of action plan for next steps

- Continual Process (survey is one way to monitor status)

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Guide to Completing the Agency Self-Assessment

Purpose

The Agency Self-Assessment for Trauma-Informed Care is intended to be a tool that will help you assess your organization's readiness to implement a trauma-informed approach. Honest and candid staff responses can benefit your agency by helping to identify opportunities for program and environmental change, assist in professional development planning, and can be used to inform organizational policy change.

How to Complete the Agency Self-Assessment

The *Self-Assessment* is organized into five main "domains" or areas of programming to be examined:

- Supporting Staff Development
- Creating a Safe and Supportive Environment
- Assessing and Planning Services
- Involving Consumers
- Adapting Policies

Agency staff completing the *Self-Assessment* are asked to read through each item and use the scale ranging from "strongly disagree" to "strongly agree" to evaluate the extent to which they agree that their agency incorporates each practice into daily programming. Staff members are asked to answer based on their experience in the program over the past twelve months.

Responses to the *Self-Assessment* items should remain anonymous and staff should be encouraged to answer with their initial impression of the question as honestly and accurately as possible. Remember, staff members are not evaluating their individual performance, but rather, the practice of the agency as a whole. Staff should complete the *Self-Assessment* when they have ample time to consider their responses; this may be completed in one sitting or section-by-section if time does not allow.

Agencies may distribute the tool in either Word or Excel format. Some agencies may prefer to use an electronic method (such as Survey Monkey) to assist with data collection and analysis.

How to Compile and Examine Self-Assessment Results

It is helpful for the agency to have a designated point person to collect completed assessments and compile the results. Detailed suggestions and The "Toolkit" are on the Trauma Informed Care Website http://www.traumainformedcareproject.org/

To identify potential areas for change, look for statements where staff responses are mostly "strongly disagree" and "disagree"; these are the practices that could be strengthened. In addition, pay attention to those responding with "do not know" as this could indicate that the practice is lacking, or perhaps there is a need for additional information or clarification. Finally, it is helpful to examine items where the range of responses is extremely varied. This lack of consistency among staff responses may be due to a lack of understanding about an item itself, a difference of perspective based on a person's role in the agency, or a misunderstanding on the part of some staff members about what is actually done on a daily basis.

This instrument was adapted from the National Center on Family Homelessness Trauma-Informed Organizational Self-Assessment and "Creating Cultures of Trauma- Informed Care: A Self Assessment and Planning Protocol" article by Roger D. Fallot, Ph.D. & Maxine Harris, Ph.D.

Trauma-Informed Organizational Self-Assessment

Please complete the assessment, reading each item and rating from strongly disagree to strongly agree based on your experience in the organization over the last year. Use your initial impression: **Remember you are evaluating the agency not your individual performance.**

Agency/Program: _____ **Today's' Date:** _____

Name of Staff (optional): _____

I. Supporting Staff Development

	A. Training and Education	**Strongly Disagree**	**Disagree**	**Agree**	**Strongly Agree**	**Do Not Know**	**Not applicable to my role**
Staff at all levels of the program receive training and education on the following topics:							
1	What traumatic stress is.						
2	How traumatic stress affects the brain and body.						
3	The relationship between mental health and trauma.						
4	The relationship between substance use and trauma.						
5	The relationship between homelessness and trauma.						
6	How trauma affects a child's development.						
7	How trauma affects a child's attachment to his/her caregivers.						
8	The relationship between childhood trauma and adult re-victimization (e.g. domestic violence, sexual assault).						
9	Different cultural issues (e.g. different cultural practices, beliefs, rituals).						
10	Cultural differences in how people understand and respond to trauma.						
11	How working with trauma survivors impacts staff.						
12	How to help consumers identify triggers (i.e. reminders of dangerous or frightening things that have happened in the past)						
13	How to help consumers manage their feelings (e.g. helplessness, rage, sadness, terror)						
14	De-escalation strategies (i.e. ways to help people to calm down before reaching the point of crisis)						
15	How to develop safety and crisis prevention plans.						
16	What is asked in the intake assessment.						
17	How to establish and maintain healthy professional boundaries.						

B. Staff Supervision, Support and Self-Care		Strongly Disagree	Disagree	Agree	Strongly Agree	Do Not Know	Not applicable to my role
18	Staff members have regular team meetings.						
19	Topics related to trauma are addressed in team meetings.						
20	Topics related to self-care are addressed in team meetings (e.g. vicarious trauma, burn-out, stress-reducing strategies).						
21	Staff members have a regularly scheduled time for individual supervision.						
22	Staff members receive individual supervision from a supervisor who is trained in understanding trauma.						
23	Part of supervision time is used to help staff members understand their own stress reactions.						
24	Part of supervision time is used to help staff members understand how their stress reactions impact their work with consumers.						
25	The agency helps staff members debrief after a crisis.						
26	The agency has a formal system for reviewing staff performance.						
27	The agency provides opportunities for on-going staff evaluation of the program/agency.						
28	The agency provides opportunities for staff input into program practices.						
29	Outside consultants with expertise in trauma provide on-going education and consultation.						

II. Creating a Safe and Supportive Environment

A. Establishing a Safe Physical Environment		Strongly Disagree	Disagree	Agree	Strongly Agree	Do Not Know	Not applicable to my role
1	Agency staff monitors who is coming in and out of the program/agency.						
2	Staff members ask consumers for their definitions of physical safety.						
3	The environment outside the organization is well lit.						
4	The common areas within the organization are well lit.						
5	Bathrooms are well lit.						
6	Consumers can lock bathroom doors.						

A. Establishing a Safe Physical Environment Continued		Strongly Disagree	Disagree	Agree	Strongly Agree	Do Not Know	Not applicable to my role
7	The organization incorporates child-friendly decorations and materials.						
8	The organization provides a space for children to play.						
9	The organization provides consumers with opportunities to make suggestions about ways to improve/change the physical space.						

B. Establishing a Supportive Environment		Strongly Disagree	Disagree	Agreee	Strongly Agree	Do Not Know	Not applicable to my role
Information Sharing							
10	The organization reviews rules, rights and grievance procedures with consumers regularly.						
11	Consumers are informed about how the program responds to personal crises (e.g. suicidal statements, violent behavior and mandatory reports).						
12	Consumer rights are posted in places that are visible (e.g. room checks, grievance policies, mandatory reporting rules).						
13	Materials are posted about traumatic stress (e.g. what it is, how it impacts people, and available trauma-specifics resources).						
Cultural Competence							
14	Program information is available in different languages.						
15	Staff &/or consumers are allowed to speak their native languages within the agency.						
16	Staff &/or consumers are allowed to prepare or have ethnic-specific foods.						
17	Staff shows acceptance for personal religious or spiritual practices.						
18	Outside agencies with expertise in cultural competence provide on-going training and consultation.						
Privacy and Confidentiality							
19	The agency informs consumers about the extent and limits of privacy and confidentiality (kinds of records kept, where/who has access, when obligated to make report to police/child welfare).						
20	Staff and other professionals do not talk about consumers in common spaces.						

		Strongly Disagree	Disagree	Agree	Strongly Agree	Do Not Know	Not applicable to my role
Privacy and Confidentiality Continued							
21	Staff does not talk about consumers outside of the agency unless at appropriate meetings.						
22	Staff does not discuss the personal issues of one consumer with another consumer.						
23	Consumers who have violated rules are approached in private.						
24	There are private spaces for staff and consumers to discuss personal issues.						
Safety and Crisis Prevention Planning							
For the following item, the term "safety plan" is defined as a plan for what a consumer and staff members will do if the consumer feels threatened by another person outside of the program.							
25	Written safety plans are incorporated into consumers' individual goals and plans.						
For the following item, the term "crisis-prevention plan" is defined as an individualized plan for how to help each consumer manage stress and feel supported.							
26	Each consumer has a written crisis prevention plan which includes a list of triggers, strategies and responses which are helpful and those that are not helpful and a list of persons the consumer can go to for support.						
Open and Respectful Communication							
27	Staff members ask consumers for their definitions of emotional safety.						
28	Staff members practice motivational interviewing techniques with consumers (e.g. open-ended questions, affirmations, and reflective listening).						
29	The agency uses "people first" language rather than labels (e.g. 'people who are experiencing homelessness' rather than 'homeless people').						
30	Staff uses descriptive language rather than characterizing terms to describe consumers (e.g. describing a person as 'having a hard time getting her needs met' rather than 'attention seeking').						
Consistency and Predictability							
31	The organization has regularly scheduled procedures/opportunities for consumers to provide input.						
32	The organization has policy in place to handle any changes in schedules.						
33	The program is flexible with procedures if needed, based on individual circumstances.						

III. Assessing and Planning Services

A. Conducting Intake Assessments		Strongly Disagree	Disagree	Agree	Strongly Agree	Do Not Know	Not applicable to my role
The intake assessment includes questions about:							
1	Personal strengths.						
2	Cultural background.						
3	Cultural strengths (e.g. world view, role of spirituality, cultural connections).						
4	Social supports in the family and the community.						
5	Current level of danger from other people (e.g. restraining orders, history of domestic violence, threats from others).						
6	History of trauma (e.g. physical, emotional or sexual abuse, neglect, loss, domestic/community violence, combat, past homelessness).						
7	Previous head injury.						
8	Quality of relationship with child or children (i.e. caregiver/child attachment)						
9	Children's trauma exposure (e.g. neglect, abuse, exposure to violence)						
10	Children's achievement of developmental tasks.						
11	Children's history of mental health issues.						
12	Children's history of physical health issues.						
Intake Assessment Process							
13	There are private, confidential spaces available to conduct intake assessments.						
14	The program informs consumers about why questions are being asked.						
15	The program informs consumers about what will be shared with others and why.						
16	Throughout the assessment process, the program staff observes consumers on how they are doing and responds appropriately.						
17	The program provides an adult translator for the assessment process if needed.						

Intake Assessment Follow-Up							
18	Based on the intake assessment, adults &/or children are referred for specific services as necessary.						
19	Re-assessments are done on an on-going and consistent basis.						
20	The program updates releases and consent forms whenever it is necessary to speak with a new provider.						
B. Developing Goals and Plans							
21	Staff collaborates with consumers in setting their goals.						
22	Consumer goals are reviewed and updated regularly.						
23	Before leaving the program, consumers and staff develop a plan to address any future needs.						
C. Offering Services and Trauma-Specific Interventions							
24	The program provides opportunities for care coordination for services not provided within that organization.						
25	The program educates consumers about traumatic stress and triggers.						
26	The program has access to a clinician with expertise in trauma and trauma-related interventions (on-staff or available for regular consultation).						

IV. Involving Consumers

	A. Involving Current and Former Consumers	**Strongly Disagree**	**Disagree**	**Agree**	**Strongly Agree**	**Do Not Know**	**Not applicable to my role**
1	Current consumers are given opportunities to evaluate the program and offer their suggestions for improvement in anonymous and/or confidential ways (e.g. suggestion boxes, regular satisfaction surveys, meetings focused on necessary improvements, etc)						
2	The program recruits former consumers to serve in an advisory capacity.						
3	Former consumers are invited to share their thoughts, ideas and experiences with the program.						

V. Adapting Policies

	A. Creating Written Policies	Strongly Disagree	Disagree	Agree	Strongly Agree	Do Not Know	Not applicable to my role
1	The program has a written statement that includes a commitment to understanding trauma and engaging in trauma-sensitive practices.						
2	Written policies are established based on an understanding of the impact of trauma on consumers and providers.						
3	The program has a written commitment to demonstrating respect for cultural differences and practices.						
4	The program has written policy to address potential threats to consumers and staff from natural or man- made threats (fire, tornado, bomb threat, and hostile intruder).						
5	The program has a written policy outlining program responses to consumer crisis/staff crisis (i.e. Self harm, suicidal thinking, and aggression towards others).						
6	The program has written policies outlining professional conduct for staff (e.g. boundaries, responses to consumers, etc).						
	B. Reviewing Policies						
1	The program reviews its policies on a regular basis to identify whether they are sensitive to the needs of trauma survivors.						
2	The program involves staff in its review of policies.						
3	The program involves consumers in its review of policies.						

Adopted from the National Center on Family Homelessness Trauma-Informed Organizational Self-Assessment and "Creating Cultures of Trauma- Informed Care: A Self Assessment and Planning Protocol" article by Roger D. Fallot, Ph.D. & Maxine Harris, Ph.D.

PEDIATRIC RESILIENCY COLLABORATIVE (PERC), SANTA BARBARA

July 24, 2019

OVERVIEW

1. Project Background and Description

The Pediatric Resiliency Collaborative (PeRC) is a community partnership convened by Cottage Health. PeRC is focused on expanding ACEs screening and referral to all pediatric clinics in Santa Barbara County and linking providers to other community systems. The partnership also seeks to facilitate knowledge sharing, collaboration, and alignment of efforts.

Key partners include, Cottage Health, Child Abuse Listening Mediation (CALM), Santa Barbara Neighborhood Clinics, CenCal Health, The Carpinteria Children's Project, Santa Barbara County Public Health Clinics, and SB County ACEs Connection / Kids Network.

The goals of PeRC are to:

- Identify high risk children at an early age via the trusted relationship of the pediatrician;
- Improve care coordination and trauma responsiveness among healthcare providers, agencies and organizations that serve children;
- Prevent trauma and adversity, promote resilience, and change the life trajectory of families who experience ACEs.

2. Project Scope

During the period October 2019 – December 2021, the project elements include the following:

- **Expand ACEs screening of children and their parents to four additional pediatric practices per year.**
- **Support practices with access to therapists and resource navigators/family advocates.**

- Serve as an information hub and resource for the full community of pediatricians interested in ACEs screening beyond those receiving more intensive technical assistance from PeRC.
- Coordinate strategies and activities with other community-based organizations and networks.
- Collaborate with state policymakers and CenCal to sustain the program with ongoing reimbursement strategies.
- Evaluate progress and outcomes using a shared evaluation approach across partners and settings.
- Determine the best approach to integrating ACES awareness education or screening within the prenatal and post-partum setting in collaboration with the Cottage Birth Center and at least one OB/GYN practice.
- Develop a research study to evaluate feasibility and best practices for ACEs screening and resource connection in the prenatal / post-partum setting in collaboration with the Cottage Health Research Institute (CHRI).

3. Roles

Cottage Health will serve as the backbone organization for PeRC. Cottage Population Health will:

1. Guide the vision and strategy
2. Support aligned activities and provide overall project management
3. Facilitate discussion and decision making among members of the Steering Committee
4. Establish shared measurement practices
5. Develop and coordinate research activities
6. Advance policy and paths to reimbursement for PeRC clinic activities
7. Support research initiatives in coordination with CHRI and other partners

Dr. Ruth of Santa Barbara Neighborhood Clinics will co-chair the steering committee and provide technical assistance and training to PeRC clinics.

CALM will provide training and therapist support to participating PeRC clinics.

Family Resource Centers located in close proximity to participating clinics will provide a dedicated navigator / family liaison to support PeRC clinics with resource navigation and referral.

Carpinteria Children's Project will provide technical assistance and training to Family Resource Center navigators.

The Cottage Birth Center will help implement ACEs education in the postnatal setting.

The Cottage Health Research Institute will support research activities with Institutional Review Board approval and dedicated statistician time.

4. Activities

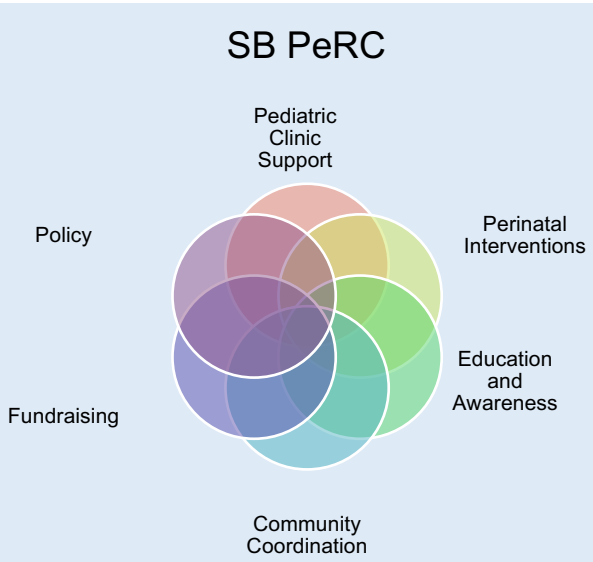
With Cottage Health serving as the backbone organization, the program will engage in the following activities:

1. Clinic Recruitment, Training, and Implementation Support:
    - Reach out to candidate clinics that have demonstrated an interest in implementing ACEs and resilience screening and secure their commitment through an MOU or other agreement.
    - Provide trainings on how to implement, evaluate, and be reimbursed for screening and referral, leveraging existing expertise and resources when possible.
    - Work with each clinic to develop a customized implementation plan, including resource mapping, and access to behavioral health clinicians.
    - Create linkages to Family Resource Centers for ongoing family advocacy, case management and resource navigation support.
    - Provide triage and navigation to all patients in need of support, through a centralized navigator / family advocate.
    - Assist with identification of and connection to payors so that clinics can be reimbursed for the above activities.
    - Provide ongoing support and troubleshooting assistance, training and connection to state and national resources for the clinic cohort.
    - Seek and take advantage of opportunities for connections and linkages to other community efforts, including school-based programs and preschool-based initiatives.
    - Track and evaluate progress using shared metrics across clinics. Track and evaluate progress for PeRC at the community level using county-wide outcomes data.

2. Education and Awareness
    - Provide education and raise awareness to the broader pediatrician community in Santa Barbara County re: ACEs/Toxic Stress, new Medi-Cal requirements, and technical assistance available via PeRC through Grand Rounds, the

American Academy of Pediatrics Central Coast chapter, and communications/marketing strategies.

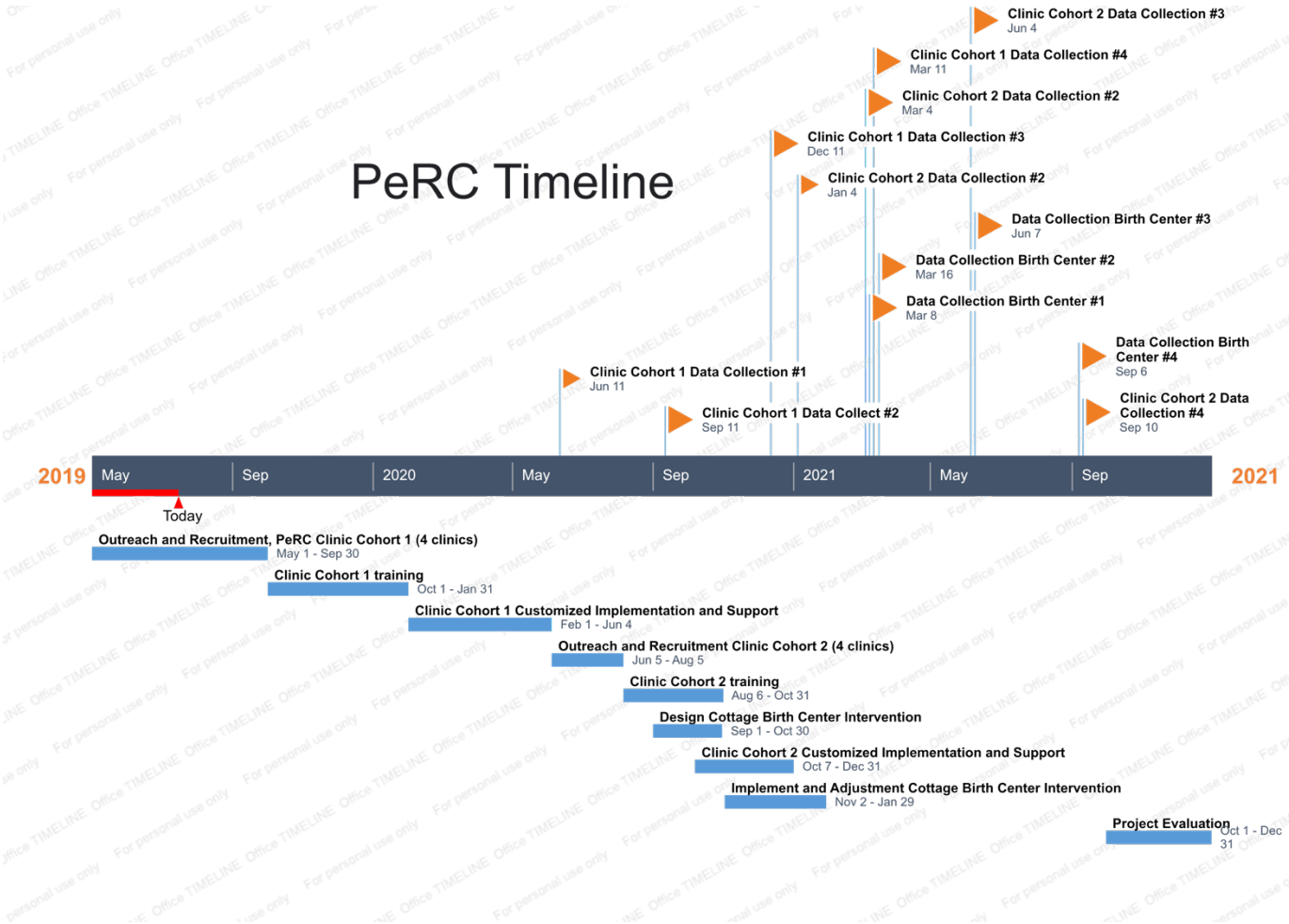
3. Cottage Birth Center
    - In collaboration with the Cottage Birth Center, design and implement an educational intervention for the birth center setting related to ACEs and toxic stress. Design a study to evaluate the feasibility of this intervention and influence on future consent to screen for ACEs / utilize services to address ACEs exposure.
4. Community Coordination
    - Connect and align PeRC goals and activities to other ACEs-focused efforts in Santa Barbara County including:
        - CALM's mental health training and support for preschools and elementary schools
        - The Santa Barbara ACEs Connection / Kids Network convened by the Department of Social Services.
5. Sustainability and Fundraising
    - Monitor, identify and pursue funding opportunities. Funding for the PeRC project in support of Cottage's role as a backbone organization has been seeded by a generous grant from the James Bower Foundation. Additional funding needed to achieve the program budget will be raised through a collaborative effort involving engaged leadership from the PeRC Task Force – with support from the SBCH Foundation Advancement office. SBCHF is available as needed to receive and hold charitable funds for the project, with Cottage Population Health monitoring and distributing resources to essential project priorities.
    - Serve as a liaison to state and regional policy efforts that impact ACEs screening and referral in SBC.
    - Inform partners and participating clinics of relevant policy developments and help them position to take advantage of them.
    - Influence policy so that it meets the needs of families in SBC.



5. Implementation Plan

Roll out will be staged by clinic readiness with implementation occurring at 2 clinics at a time on a rolling basis. Birth Center interventions will be implemented in January 2020 after collaborative planning with CHRI and Birth Center staff. Policy and community coordination-related activities are ongoing, and in partnership with ACEs Connection Santa Barbara and the Center for Youth Wellness.

See Appendix: Timeline


PeRC Timeline
Clinic Cohort 2 Data Collection #3
Jun 4
Clinic Cohort 1 Data Collection #4
Mar 11
Clinic Cohort 2 Data Collection #2
Mar 4
Clinic Cohort 1 Data Collection #3
Dec 11
Clinic Cohort 2 Data Collection #2
Jan 4
Data Collection Birth Center #3
Jun 7
Data Collection Birth Center #2
Mar 16
Data Collection Birth Center #1
Mar 8
Data Collection Birth Center #4
Sep 6
Clinic Cohort 1 Data Collection #1
Jun 11
Clinic Cohort 1 Data Collect #2
Sep 11
Clinic Cohort 2 Data Collection #4
Sep 10
2019
May
Sep
2020
May
Sep
2021
May
Sep
2021
Today
Outreach and Recruitment, PeRC Clinic Cohort 1 (4 clinics)
May 1 - Sep 30
Clinic Cohort 1 training
Oct 1 - Jan 31
Clinic Cohort 1 Customized Implementation and Support
Feb 1 - Jun 4
Outreach and Recruitment Clinic Cohort 2 (4 clinics)
Jun 5 - Aug 5
Clinic Cohort 2 training
Aug 6 - Oct 31
Design Cottage Birth Center Intervention
Sep 1 - Oct 30
Clinic Cohort 2 Customized Implementation and Support
Oct 7 - Dec 31
Implement and Adjustment Cottage Birth Center Intervention
Nov 2 - Jan 29
Project Evaluation
Oct 1 - Dec 31