Aligning Hospitals to Promote Trauma-Informed, Healing-Centered Transformation in Chicago

The Illinois ACEs Response Collaborative

Health & Medicine POLICY RESEARCH GROUP

Introduction

In 2017, Health & Medicine Policy Research Group's Illinois ACEs Response Collaborative (the Collaborative), the Chicago Department of Public Health (CDPH), and the Alliance for Health Equity (AHE) partnered to establish the Trauma-Informed Working Group (the Working Group) of the AHE, a group of 18 Chicago-area hospitals and health care systems working to become trauma-informed. The Working Group was formed to strategically advance the city's public health agenda, known as Healthy Chicago 2.0, which included establishing Chicago as a trauma-informed city among its desired outcomes. Chicago set this ambitious goal because it recognized that adversity and trauma, including violence, are at the root of poor health and social outcomes and that improving health and health equity requires trauma-informed, healing-centered (TIHC) transformation in attitudes, knowledge, research, and practices across agencies, organizations, sectors, and systems.

The Working Group was the first of its kind nationally to unite hospitals and health care systems to begin to bring trauma-informed transformation to scale; it remains a leader in the field, with its co-chairs presenting at national conferences and providing technical assistance to others seeking to replicate this model. It provided, and continues to offer, an unprecedented opportunity for organizations that ordinarily compete to come together and share resources, think collectively, problem solve, and learn from national best practices and emerging evidence in order to implement systems change.

Given the increasing attention being paid to TIHC care in health care settings, this report aims to share the learnings of the Working Group. It will review the hospital members' journeys with a focus on eight that participated in qualitative interviews, highlighting their successes and challenges, discussing plans for sustainability moving forward, and describing the role of the Working Group in guiding progress. It is our hope that the insights presented here will provide direction for health care institutions and other organizations pursuing TIHC transformation.

Trauma-Informed Working Group Overview

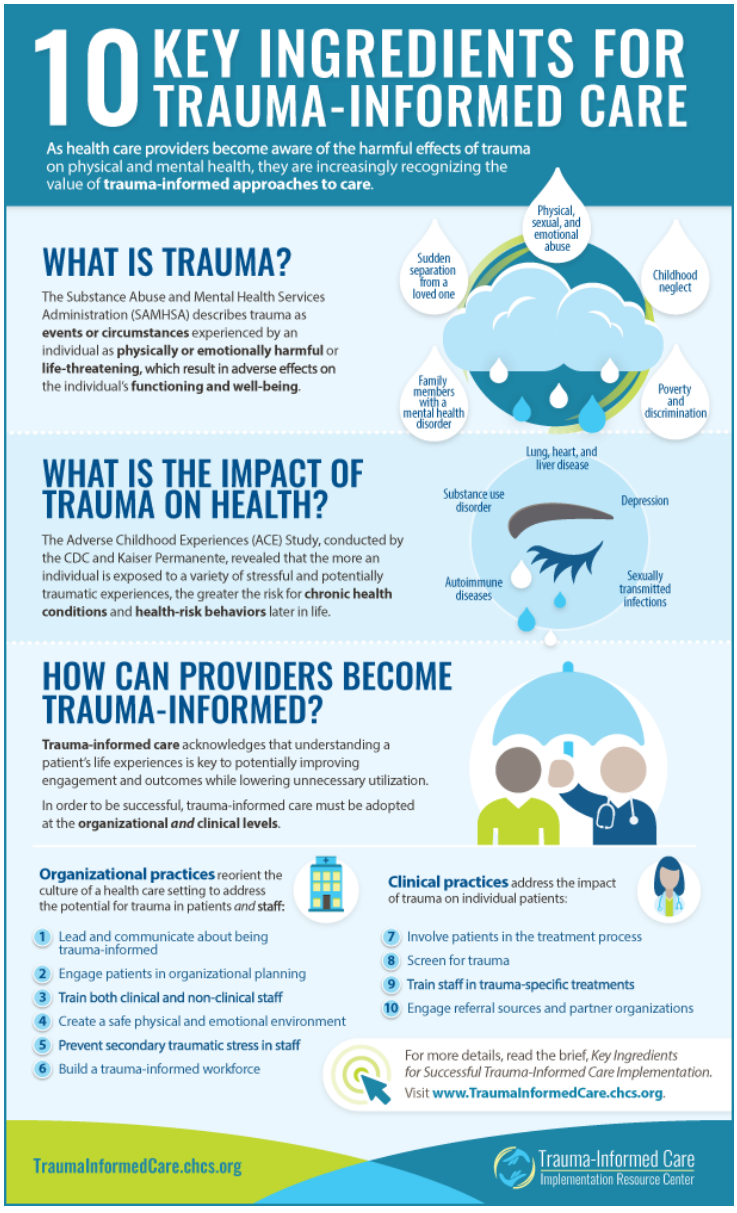
The Working Group is a learning community led by co-chairs from the Collaborative and CDPH's Office of Violence Prevention and Behavioral Health. Since 2017, the Working Group has grown from 15 institutional members to 18. These institutions vary in size and management; they include safety net and community hospitals, academic medical centers, and faith-based networks. Each hospital or system is represented by one to two people in the Working Group. These individuals occupy a range of roles, including but not limited to Director of Community Affairs, Director of Behavioral Health, Chair of the OB/GYN Department, Director of Violence Prevention, and Vice President of Mission and Spiritual Care. Since the inception of the Working Group, several hospital system mergers and acquisitions have impacted members, yet participation has remained strong and consistent.

The Working Group is structured to encourage regular collaboration and learning. The group has met every six weeks for over three years. Meetings have four primary objectives for attendees: to hear from national experts; to share promising practices with each other; to brainstorm possible solutions to obstacles to success; and to learn new skills and gain access to tools that help advance TIHC transformation. Guest speakers are leaders in this work and come from organizations across the country, including Saint A, Milwaukee Children's Hospital, Montefiore Medical Group, Ballad Health, and

Brigham and Women's. During meetings, members also provide updates on their own progress and the co-chairs share new tools, upcoming events, and other relevant news.

The Collaborative and CDPH have shared several tools to help Working Group members advance their work. These tools are organized into the Trauma-Informed Care Best Practices Toolkit, a web-based toolkit to support hospitals and other health care organizations move along the continuum of TIHC transformation from trauma aware to trauma-informed, trauma-specific, and healing centered care. Resources include background information on childhood adversity, early life stress, and healthy development; videos on TIHC care; organizational and professional assessment tools; and strategies to address health care team burnout through cultivating staff wellness. CDPH shared its Trauma-Informed Transformation Project logic model as well as the baseline assessment tool that it administered to all staff. The Toolkit includes links to the Collaborative's reports, webinars, and newsletter, as well resources it has developed, including:

- Guide for Starting and Leading Your Hospital's Trauma-Informed Working Group: provides resources and strategies to guide individuals in creating an internal team to support trauma-informed transformation
- Trauma-Informed Care: Laying the Groundwork for Investment by Healthcare Systems: provides key background information about the science behind TIHC care; how it can improve patient outcomes; the economics of TIHC care; and the impact of secondary trauma on provider burnout
- Sample slide deck presentation for engaging leadership
- Supporting the Healthcare Workforce: Understanding Burnout, Its Impacts, and What Can Be Done About It: includes an overview of burnout, including its prevalence, consequences, drivers, and costs, and delves into strategies to prevent burnout and mitigate its impact
- Visioning and action plan templates to manage trauma-informed transformation



Drawing from the guidance of national leaders like the Center for Health Care Strategies and the San Francisco Department of Public Health[1], the Working Group collectively prioritized several types of strategies for hospitals' TIHC change work. Individual members implemented the strategies most likely to be achievable in their specific hospital environment. In some cases, the Collaborative

[1] More information about the the San Francisco Department of Public Health's Trauma-Informed Systems Initiative can be found in the Collaborative's webinar with Dr. Kenneth Epstein, available here.

provided tailored technical assistance to implement these strategies. For example, Collaborative staff have organized and acted as keynote speakers for conferences and grand rounds at hospitals, presented to senior leadership, led trainings, and connected members with funding opportunities.

The Working Group co-chairs organized several events for member hospitals and actively worked to engage hospital leadership. For example, in 2017 the Collaborative convened 55 hospital leaders for a meeting with national organizational change expert Dr. Sandra Bloom of the Sanctuary Model[2]. In addition to organizing this convening, the Collaborative later provided members with slide decks to use for presentations to leadership. In some cases, the Collaborative presented to hospital executives on behalf of Working Group members.

Methods

To understand the unique experiences of the various hospital members of the Working Group, qualitative interviews were conducted with eight individuals from different institutions in the summer of 2018 and winter of 2019. Interview questions were created in accordance with the 10 implementation domains of the Substance Abuse and Mental Health Services Administration (SAMHSA) model[3]. (CDPH adopted this model in full for its own internal TIHC organizational transformation work.) Additional information for this section was culled from Working Group meeting minutes and other reporting tools used to track member progress. It is important to note that these interviews pre-date the COVID-19 pandemic and the national protests and conversations around racial equity, which Collaborative members report has further illuminated the need for TIHC care and is deepening their organizations' commitment to this transformative work.

Findings

Findings at a Glance
- Motivation to Pursue Trauma-Informed Transformation
- Model of Trauma-Informed, Healing-Centered Transformation
- Getting Buy-In from Leadership and Staff
- Baseline Staff Assessment
- Internal Trauma-Informed Workgroups
- Trainings
- Trauma-Informed, Healing-Centered Initiatives/Pilot Programs
- Community-Based Organizations
- Evaluation

Motivation to Pursue Trauma-Informed Transformation

Members pursued trauma-informed transformation at their institutions for multiple reasons. First, as noted earlier, the City's public health agenda, Healthy Chicago 2.0, was released in 2016 and included a goal of making Chicago a trauma-informed city. Interviewees explained that they could cite the City's commitment as a reason their own hospital should pursue comprehensive trauma-informed transformation internally and contribute to the collective citywide goal. Some said they felt a responsibility to lead this work themselves because of this goal. Next, many members described that in their hospitals, individual TIHC strategies were being implemented in isolation or in single departments; there was no comprehensive strategy to pursue institution-wide culture change. This motivated them to pursue organization-wide TIHC change.

Health equity was another strong motivator for many institutions. All the Working Group members are also part of the Alliance for Health Equity, a collaborative of hospitals united to improve health and support equity for all residents across Chicago and Cook County through identifying and addressing social and structural determinants of health. Interviewees explained they did not believe their institution could

[2] http://www.sanctuaryweb.com/
[3] https://store.samhsa.gov/product/SAMHSA-s-Concept-of-Trauma-and-Guidance-for-a-Trauma-Informed-Approach/SMA14-4884

effectively and sincerely work towards addressing health inequities without incorporating a TIHC approach. One interviewee said that they also felt that addressing ACEs and trauma allowed for pediatric intervention and care to be prioritized in health equity programming. Previously, the interviewee noted, TIHC work has been centered around reactive treatment in adults, rather than prevention in children, adolescents, caregivers and adults at large.

Finally, the benefits of TIHC care for specific programs and underserved patient populations motivated some systems to move forward. One interviewee noted that pregnant patients were already being screened for ACEs as part of a pilot program at their hospital but that there were no procedures in place to protect these patients from potential re-traumatization, nor were residents and other students consistently trained on the relevance of screening patients for childhood trauma. To remedy this, the hospital created an internal working group to disseminate a more comprehensive set of TIHC practices across the organization. Another individual remarked that trauma-informed work began as a way to improve the care of domestic and sexual violence survivors. Trauma-informed practices were adopted by the violence prevention team, which has since led the charge for hospital-wide transformation citing the success seen in their work with survivors.

Model of Trauma-Informed, Healing-Centered Transformation

Most institutions utilized SAMHSA's *Concept of Trauma and Guidance for a Trauma-Informed Approach* to inform their work. One hospital stated that it was a natural fit as staff "are familiar with it [SAMHSA]." Others felt that SAMHSA's framework provided insufficient operational guidance. While this framework details the principles and desired outcomes of a TIHC approach—elements like feelings of safety, collaboration and mutuality between staff, and peer support—it does not provide specific action steps or a timeline to follow. For this reason, one hospital is utilizing the Sanctuary Model developed by Sandra Bloom, MD. This model, they report, is more suited to their needs as it includes curricula and toolkits with practical tasks and timelines. It is important to note that, unlike with SAMHSA's approach, there is a cost associated with accessing the Sanctuary Model resources. The member hospital following the Sanctuary Model has not purchased access to the all the materials; rather, it is basing its work off of the Sanctuary books. Most institutions, however, did not follow a more specific model; instead, they relied on the guidance of the Working Group and promising practices gleaned from guest speakers.

Getting Buy-In from Leadership and Staff

Leadership engagement varied across institutions. Members reported that at many institutions, their leadership was enthusiastic about TIHC care but remained reluctant or unable to devote resources to it. In part, this was because they felt the financial case for investment was insufficient due to limited evaluation and research on outcomes. Others had difficulty convincing their leadership that TIHC care aligned with organizational priorities and would help achieve existing organizational goals. Still other executive teams felt that TIHC care was merely a current "trend" and did not think the hospital should make a financial commitment to changes this approach would require. Some interviewees felt that leadership with clinical training was more accepting of TIHC care than those with business or other backgrounds.

Interviewees adopted an array of strategies to promote buy-in among leadership, including:

- Providing TIHC informational and training sessions for all leadership and managerial staff, including those in non-clinical positions; at one institution, 800 leadership staff received training on compassion fatigue, self-care, and supporting providers.
- Making the case for how and why TIHC care aligns with key hospital indicators (i.e., improving employee engagement, reducing staff turnover); one member presented first to Human Resources and Organizational Development leadership, who then helped make "a business case for trauma-informed practices" to the Chief Executive Officer and Chief Medical Officer by highlighting the role of staff trauma in turnover, sick days, and employee conflict.
- Conducting a "listening tour" that included conversations with leaders from multiple departments and levels including the Director of Human Resources; Vice Presidents of Nursing, Risk Management, and Finance; and the Chief Medical Officer; this helped TIHC champions situate their work within the strategic priorities and needs of the hospital.

Working Group members also prioritized developing staff support for TIHC transformation. One commonly reported barrier was a limited understanding of trauma. Some staff members felt that TIHC care was only relevant in institutions that had trauma units. Others said that while staff were interested, they believed that TIHC care belonged under the purview of the behavioral health department and was not relevant to their work as orthopedists or cardiologists, for example. Buy-in was cultivated when staff learned the full definition of trauma and how it impacts myriad physical, mental and social health outcomes across the lifespan, beyond the work of the trauma or behavioral health unit. Members reported that staff were also motivated by learning about the impact of their own traumatic experiences as well as the trauma of witnessing or hearing about the suffering of others on their own wellbeing. They connected best with information on how TIHC approaches support staff wellbeing, improve staff's own health, strengthen relationships with patients and with their own family and friends, and have the potential to improve patient outcomes and satisfaction.

Baseline Staff Assessment

The Working Group encouraged members to administer a baseline staff assessment to inform their work. As leaders of Chicago's Trauma-Informed City initiative, CDPH had conducted its own baseline survey and generously shared its tool with the group. This tool was based on staff and clients'/patients' experience of traumatic stress, and also measured knowledge, skills, practices, and sense of safety. The Working Group adapted this assessment to better fit the hospital setting in general. A few members adapted it further for their own setting and were able to administer it. One hospital disseminated the survey to all managerial staff when they attended a Trauma 101 training. Another modified the survey so it would assess how best to deliver training efficiently at their institution. One hospital developed and implemented its own internal survey. Others reported that the shared assessment helped strengthen executive buy-in because they could share that other Working Group members had administered the survey in their institutions, thereby fostering a sense of possibility as well as healthy competition. The assessment also raised the profile of TIHC work among all staff and acted as an educational tool itself.

Those institutions that did not implement the assessment cited a few primary factors. Some did not yet have senior leadership buy-in. For others, staff had "survey fatigue" in response to the concurrent administration of too many other surveys. A few felt that they were not ready to administer a hospital-wide survey as they did not yet have a comprehensive strategy that could be implemented after the survey. Many hoped that they would be ready for the baseline assessment inthe near future.

Internal Trauma-Informed Workgroups

Trauma-informed transformation was an additional responsibility added to an already full workload for most Working Group members, and they did not receive additional time or compensation for this work. To increase bandwidth, deepen staff engagement, and coordinate across departments, members were encouraged to start or grow their own internal trauma-informed workgroups. To support them, the Collaborative developed a document with guidance about starting and leading workgroups, as outlined above. Eight hospitals established internal workgroups. One hospital situated their workgroup within the behavioral health department. Others were intentional about having representation from a diverse group of departments. They included clinical units such as emergency medicine, pediatrics, family medicine, internal medicine, OB/GYN, behavioral health, and psychiatry. Many also included non-clinical departments such as population health, human resources, public safety and emergency management, resident education, and pastoral care/chaplain services. At one institution, a steering committee was established with senior leadership (including the Chief Nursing Officer and the Chief Diversity, Inclusion, and Equity Officer) and a second workgroup was also created with a range of individuals, including the Assistant Director of Public Safety, Manager of Spiritual Care, staff nurses, and a few MDs.

Members reported varying levels of activity for their workgroups. Some groups met monthly, using the time to learn together about TIHC care; assess what initiatives were already in place across their institution; strategize about how to align TIHC strategies with the hospital's priorities; and conduct outreach to leadership and other key stakeholders. Others met on an ad hoc basis and utilized members' standing within the hospital to appeal to leadership. Some Working Group members worried that although they led the workgroup and TIHC work generally, they did not feel confident in their knowledge or overall capacity to effect change across the whole institution. Regardless, people reported that workgroups were an asset in their TIHC transformation work.

Trainings

Holding staff trainings on trauma and trauma-informed care was a tangible step that many member institutions pursued. The scale and format of these trainings varied. Several hospitals used training to develop buy-in from senior leadership as explained above. One hospital trained all managerial staff from every department so that managers could connect teams to resources and lead culture change. This hospital plans to hold additional trainings for their team members in the future. Others have trained by department, either focusing on specific departments such as pediatrics and behavioral health or by working with those departments that request trainings. Another popular approach was to present this information as part of provider grand rounds. One institution developed a new virtual training program about trauma that will be sent to all pediatricians; online trainings will be supplemented with in-person debriefing. Finally, several members attended a train-the-trainer session held by CDPH which taught them how to lead the City's Trauma 101 module at their respective institutions. Training at scale was challenging, however, especially given rates of staff turnover and the short cycles of resident and fellow employment.

The content of the trainings varied. Some training materials have come from CDPH and the Collaborative while others were developed internally. Topics included an intro to ACEs, trauma, and TIHC care, as well as burnout, compassion fatigue, and secondary trauma. One hospital taught self-care strategies to residents, which was anecdotally very impactful, although the interviewee did not share evaluation data. Some hospitals have incorporated content on trauma and healing into preexisting training modules on topics such as implicit bias or mandated reporter requirements. In general, interviewees felt that having a physician present the material was best when the audience consisted of physicians. Regardless of the format and content, the focus of trainings was to disseminate the information as widely as possible given the limited resources.

Trauma-Informed, Healing-Centered Initiatives/Pilot Programs

Several pilot and focused programs have been launched to advance TIHC transformation. In one hospital, a Working Group member started a program in the OB/GYN department's residency clinic to refer pregnant teens and women with an ACE score of four or higher to trauma-informed home visiting programs. With the recognition that staff wanted to develop more wellness and resilience skills, another hospital began a mindfulness program for emergency department (ED) staff. Participants, mostly ED nurses, participate in mindfulness training twice a week for 10 weeks. This hospital also started implementing Schwartz Rounds, a regularly scheduled time for multi-disciplinary staff during the workday to openly and honestly discuss the social and emotional issues they face in caring for patients and families[4]. Finally, another hospital addressed staff burnout through a resilience building program led by the chaplain's office. In this eight-week program, two chaplains led resilience and reflection rounds to help prevent and respond to burnout through open door individual reflection time, educational presentations, and hospital community meetings. Departments often excluded in these types of programs—such as infection control—have been included to ensure comprehensive support is provided

[4] https://www.theschwartzcenter.org/programs/schwartz-rounds

across the institution. These are just a few of the examples of the many initiatives members have implemented since the start of the Working Group in 2017.

Community-Based Organizations

Member institutions have connected with community-based organizations (CBOs) and community members in their TIHC work to varying degrees. All institutions had relationships with CBOs, and many say they are beginning to engage these partners in the TIHC transformation process as part of their overall community engagement work. Some institutions used specific patient concerns—such as community and domestic violence—to guide their partnership process. Others point to their institution's Community Health Needs Assessment as the catalyst for connecting with organizations.

Once connected, the institutions found a high level of interest in TIHC practices and support from these organizations. One hospital has provided its own trauma and healing trainings to 20 partner organizations and is providing ongoing technical assistance. The Collaborative led an ACE Interface training—the nationally recognized curriculum developed by Dr. Rob Anda and Laura Porter—for more than 20 CBOs affiliated with and recommended by Working Group member hospitals. Many hospitals report that their community partners have been adopting their own TIHC practices, and these partnerships have been an opportunity for hospital staff to learn from professionals who are more embedded within the community.

Some institutions also report getting feedback and gaining insight from patients and community members. One hospital conducted focus groups with community members to help determine what kind of programming would best serve their needs, while others have connected with community block clubs and outreach programming to discuss TIHC transformation. Despite these inroads, all interviewees expressed a desire to engage more with patients and community members. Some said they hope that once TIHC practices are more established internally they will be able to share them more easily with the community at large. Another member expressed the hope for the creation and administration of a patient assessment or survey to not only monitor the hospital's progress, but also to collect ideas on what would best serve patient needs.

Evaluation

Evaluation of TIHC work is in nascent stages among Working Group members, which is very much in line with national trends for TIHC organizational transformation—the authors know of no comprehensive evaluations published in peer reviewed journals. Members aligned around a shared staff assessment tool adapted from the one used by CDPH, and a few administered it, as described above. One member sent its own trauma-informed care survey to a broad cross-section of over 900 employees and received almost 200 responses. The purpose of this survey was to assess staff knowledge and use of TIHC as well as staff experiences with secondary trauma. Many hospitals report using pre/post tests to evaluate specific trainings or administering surveys in specific departments. Others have been planning an organization-wide assessment of TIHC practice but report difficulties agreeing on organizational priorities. The Working Group is currently reviewing the literature to support development of appropriate indicators for assessing TIHC practice and organizational change.

To assist with evaluation, the Collaborative has begun a project examining the return on investment (ROI) for trauma-informed care. Early findings are consistent with Working Group members' implementation experience; the elements of TIHC transformation have not been clearly defined nor do any rigorous evaluations of TIHC transformation in health care settings exist in the published literature. More findings from the Collaborative's ROI project are forthcoming, and we anticipate this information will help support systems change in hospitals and health care organizations across the country.

Facilitators of Success

Facilitators of Success at a Glance
- Having influential champions of TIHC transformation, such as senior leadership and physicians
- Interdisciplinary internal workgroups
- Working towards quicker, smaller scale successes
- Collaborating with other hospitals in the Working Group

Working Group members identified several facilitators of their success. They stressed the importance of having influential champions of TIHC transformation. These champions included individuals with access to senior leadership who can keep this topic central to hospital-wide conversations. Having a physician champion who can present to other physicians, residents, and medical students is essential, as are supportive department heads. Additionally, interdisciplinary internal workgroups were identified as a key to success, as they were able to unify disparate departments and initiatives while amplifying the work being done. They also provided critical support to Working Group members; one said, "Just by getting together, you don't feel alone with this and can begin collaborating across departments. It keeps you going…" Lastly, interviewees stressed the importance of working towards quicker, smaller scale successes that could be recognized as benefits of TIHC transformation. This helped deepen buy-in among leadership and staff alike.

The Working Group itself was also cited as a facilitator of progress by all interviewees. Many said the chance to collaborate with other hospitals and learn from one another was a significant asset:

> *"It has been great to be connected to what other hospital institutions are doing. You don't feel alone with this…. It keeps you going and makes you feel more confident that this is the right direction."*

Another person noted that the Working Group added "a sense of respectability" for leadership at their institution since it involved so many different hospitals and CDPH. Still another mentioned a healthy sense of competition that resulted from bringing together so many of the city's hospitals; they were able to leverage the work that other hospitals were doing to make progress in their own system. The tools, national speakers, and trainings that members accessed through the Working Group were also universally recognized as immensely beneficial in advancing this work.

Challenges

Challenges at a Glance
- Lack of financial resources
- Difficulty leading an institution-wide effort
- Changes in local, regional, and national health care landscape
- External pressures like changes to the state budget, Medicare, and Medicaid rules
- Language of TIHC care

The most common challenge to this TIHC transformation work was a lack of financial resources. While many people said their leadership approved of the TIHC process "in spirit," they were still unlikely to allocate funds for the changes suggested—even when TIHC transformation was included in the hospital's strategic plan. One interviewee noted that leadership at their hospital was surprised by the initial cost of action items such as evaluation or training and scaled back their enthusiasm once these were revealed.

Without financial resources, most member institutions did not have full-time staffing positions committed to TIHC care; Working Group members were leading these efforts in addition to their full-time role without additional compensation. Because organization-wide culture change requires dedication and time, especially in complex, large hospitals, several respondents felt that the lack of staff resources was a primary reason that progress stalled. Insufficient resources meant that coordination across the whole

organization was lacking; two interviewees discussed how they learned about parallel but isolated efforts at their institutions which would have benefitted from working together. Many respondents felt that there was no way they could lead a cohesive, institution-wide effort; instead, strategies were often implemented department by department in piecemeal fashion.

Achieving and maintaining leadership buy-in was particularly challenging given the changes in the local, regional and national health care landscape. Due to several health care system mergers and acquisitions, members often found themselves orienting one set of leaders to TIHC care only to learn that they would soon have new leadership after their hospital was acquired by another system. Additionally, leadership had to be responsive to external pressures like changes to the state budget, Medicare, and Medicaid rules and while prioritizing costly health conditions like diabetes, which they did not fully understand would benefit from a TIHC approach because childhood adversity is at the root of these conditions—making it challenging for them to TIHC transformation.

Finally, several people reported that the language of TIHC care was a barrier to developing staff buy-in. Some hospital staff felt that TIHC work was not relevant to them because they were not a trauma center. Others associated trauma either with physical experiences or with behavioral health concerns; either way, they did not see it as relevant to their work. Interviewees stressed the need for staff to feel "equal ownership," saying that "cultural change is something we are all responsible for, not just leadership." Therefore, Working Group members worked to broaden people's understanding of the concept of trauma and healing and help them understand how TIHC care best supports everyone in a health care setting.

Planning for Future

After almost three years together, the Working Group found itself at a critical moment of reflection. The co-chairs encouraged members to complete a visioning exercise and action plan for the future of TIHC transformation at their institution. Members were asked to envision their ideal scenario for TIHC work at their hospital in one year and five years as well as to think about the tools and partners they would need to achieve their vision. Three key themes emerged:

- **Senior leadership buy-in, including financial resources:** Many members wanted buy-in from leadership. Specifically, they were hoping for a financial commitment that would create a full-time position to lead the TIHC work and also fund training and other resources. Several members also hoped that leaders would more actively promote TIHC transformation and culture change at their institutions. One member reported that the integration of TIHC language into their institution's strategic plan was the first step toward this but that they would like that to be disseminated, promoted, and accepted throughout the health system.

- **Curricula and training:** Offering regular TIHC trainings and adopting a TIHC curriculum was another common goal. For some members, this meant beginning to offer trainings or expanding on what was already offered. Others hoped that training would become universal and required for all staff. Some discussed the goal of making an introductory training to TIHC care part of their mandatory onboarding process while others simply wanted a commitment from leadership that trainings would be available. Again, there was a recognition that expanded training would require a paid staff position dedicated to leading this work.

- **System-wide integration**: Members reported goals around embedding TIHC policies and practices throughout the culture of their institution. These goals varied and included adopting human resources policies for new staff (related to orientation) and current staff (related to conflict resolution and reviews); ongoing programming to reduce staff burnout and secondary trauma; increased staff support for critical incidents; training all staff-not just clinicians- in THIC practices to establish a system-wide baseline of knowledge; integrating TIHC language in all internal and external communication; renovating the building to be more TIHC; and formally

evaluating all TIHC efforts. One hospital summarized the idea of system-wide integration by saying their ultimate goal was a hospital that was "obsessed with being trauma-informed," with leadership and staff fully committed to supporting the movement not just within the hospital, but the community at large.

Reflections on Facilitating the Working Group

As co-chairs, the Collaborative and CDPH had a unique bird's-eye view of member institutions and learned a significant amount about leading this kind of voluntary working group. First and foremost, we had the opportunity to support committed individuals who were implementing inspiring and successful work at their institutions. Participants came to the Working Group out of a genuine desire to deepen support for staff and improve care for patients, and they had a thirst to learn and do more. Members fully supported each other's efforts. Hospitals are often perceived as unwilling to share information with one another, certainly true at times locally. This process was the converse of that: people were hungry to share their successes and challenges to advance the collective goal of becoming TIHC institutions.

Leading this group required flexibility from the co-chairs to accommodate the different styles, needs, and approaches of each of the hospital systems. Though all could benefit from TIHC transformation, each institution had different strategic priorities and varied resources that influenced how they moved this work forward. Additionally, we grew to recognize that progress would be slow and that topics might need to be revisited several times during Working Group meetings, especially because members were leading TIHC initiatives in addition to other full-time responsibilities. Ideally, we would have provided more individualized technical assistance to members between meetings, but we did not have the staffing capacity to manage that.

Moving forward, we hope to formalize membership in the Working Group through funding and formal agreements to encourage progress. The Collaborative received annual grant funding that supported limited staffing for this work; member hospitals did not receive funds tied to the Working Group. Related, hospitals did not sign an agreement or MOU to be part of the Working Group. While individuals had the best of intentions to advance the work, there was no financial incentive or agreement to which institutions were held accountable. We hope to get a large, multi-year grant that would support the facilitation work of the co-chairs, provide funding to the hospitals themselves, and fund research and evaluation efforts.

Conclusion

Throughout its tenure, the Trauma-Informed Working Group has provided Chicago-area hospitals with a unique opportunity to collaborate in advancing trauma-informed transformation. From the safety net, to small community hospitals, to large teaching institutions, member hospitals serve every population in Chicago. The Working Group has acted as a resource, connecting members to national experts, emerging best practices, and a range of tools. It has also provided a space to share ideas and come together around the common goal of providing trauma-informed, healing-centered health care to the entirety of Chicagoland.

Moving forward, the Working Group will continue to provide this opportunity for ongoing collaboration. Members have reiterated their commitment to the group, voicing their desire to have regular check-ins to update each other and learn together. They explained that this holds them accountable and gives them ideas for how to move their work forward. Some members would like deeper connections between hospitals, suggesting site visits and attending each other's workgroup meetings. The Working Group co-chairs plan to more deeply engage hospital leadership and to explore funding opportunities that would support multi-year, multi-hospital engagement.

The Working Group remains committed to convening Chicago's diverse hospitals to engage in ongoing mutual learning and action as we deepen trauma-informed healing centered transformation within these institutions and across Chicago.

About the Illinois ACEs Response Collaborative

Established in 2011, the Illinois ACEs Response Collaborative (the Collaborative) represents a broad range of organizations and agencies committed to expanding and deepening the understanding of the impact of childhood trauma and ACEs on the health and well-being of Illinois families and communities. The Collaborative works to catalyze a cross-sector movement to prevent trauma across the lifespan and to place the impact of childhood experience on wellbeing at the forefront of the equity agenda in Illinois. Our vision is a thriving and equitable Illinois in which individuals, families, communities, and all systems and sectors work together to prevent trauma, heal, and flourish.

About Health & Medicine Policy Research Group

Health & Medicine is a Chicago based non-profit working to improve the health of all people in Illinois by promoting health equity. Founded in 1981 by Dr. Quentin Young, it was formed as an action-oriented policy center—nimble, independent, and focused on regional health issues. Health & Medicine's mission is to promote social justice and challenge inequities in health and health care. It conducts research, educates and collaborates with other groups to advocate policies and impact health systems to improve the health status of all people. Health & Medicine has successfully developed health policy recommendations and implementation strategies for different public and private entities, earning the trust of the legislature, advocates, the media, researchers and policymakers at all levels of government in Illinois to become the region's "honest broker" on healthcare policy matters. Learn more at www.hmprg.org.

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