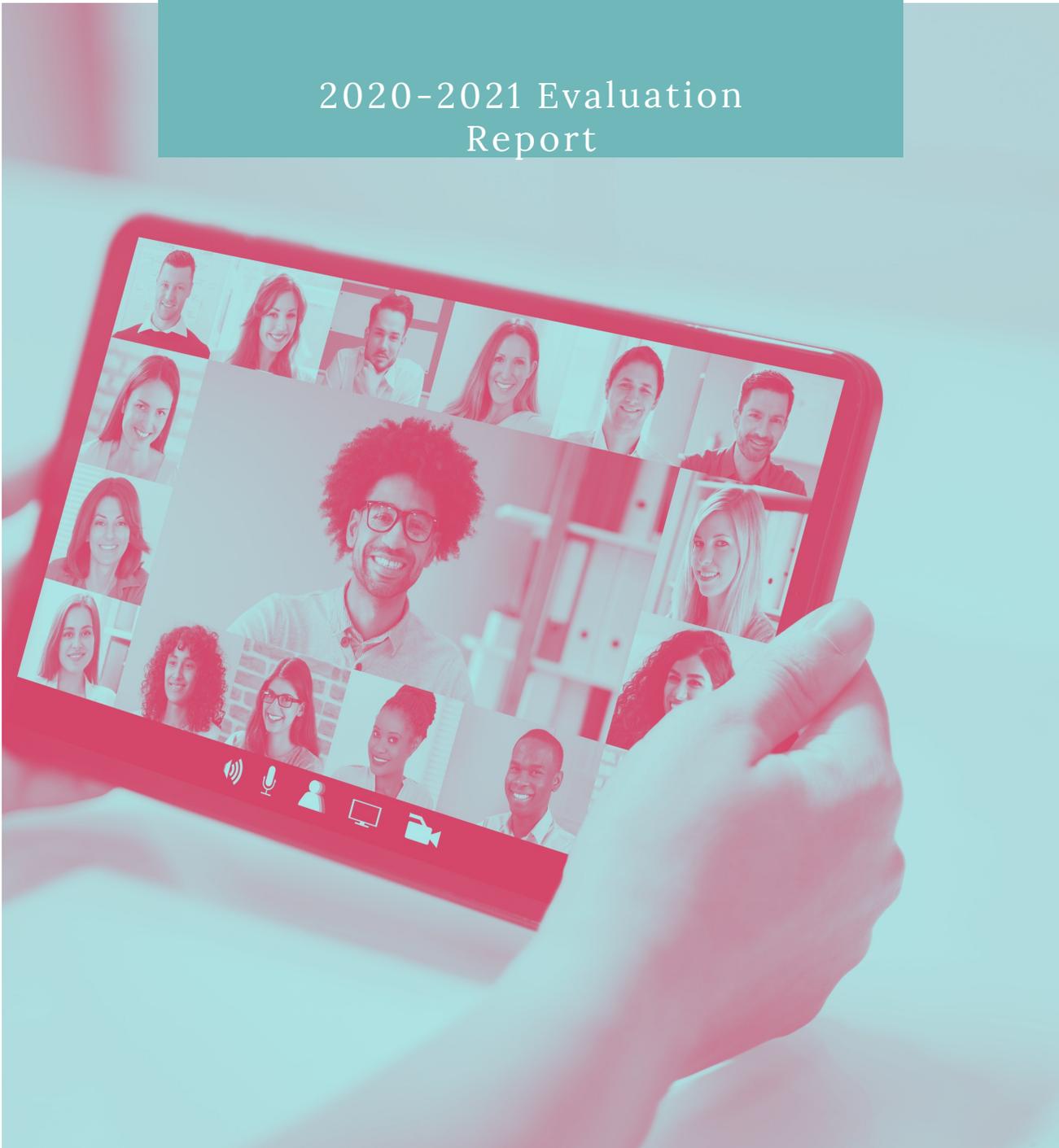


# CALIFORNIA ACES ACADEMY

2020-2021 Evaluation  
Report





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## PROGRAM BACKGROUND

The state of California awarded a \$200,000 ACEs Aware Supplemental Provider Training grant to four non-profits working in collaboration to educate Medi-Cal providers and others on the importance of Adverse Childhood Experiences (ACEs) to health. The four non-profits included the Academy on Violence and Abuse (AVA), The American Professional Society on the Abuse of Children (APSAC), the California Professional Society on the Abuse of Children (CAPSAC), and the Center for Innovation and Resources, Inc. (CIR), referred to collectively as CALIFORNIA ACES ACADEMY.

The AVA is a national and global organization dedicated to educating health professionals and the community about the health effects of violence and abuse throughout the life course. AVA originated the Regional Academy model in 2014 and has conducted 15 Regional Academies throughout the United States, Hong Kong, Shanghai, and Seoul educating health professionals and communities. AVA initiated the collaborative effort and reached out to APSAC, CAPSAC, and CIR to form CALIFORNIA ACES ACADEMY. The AVA Regional Academy model was adapted to the CALIFORNIA ACES ACADEMY for the ACEs Aware grant.

APSAC is a national and global multi-disciplinary professional society dedicated to helping professionals in the child maltreatment field utilize evidence-based practices to prevent child maltreatment as well as to identify and treat child victims and families. APSAC was selected to be the fiscal sponsor for the ACEs Aware grant to provide fiduciary oversight, financial management, and administrative services for the grant.

CAPSAC is the California state chapter of APSAC and shares the same mission, vision, and commitment as APSAC. CAPSAC was selected to contribute its extensive experience in educating health professionals in California.

CIR has more than a decade of experience applying research-based knowledge to address real-world problems in human services and education through training and support. CIR works to optimize established programs and services so that children, families, and communities are served in a coordinated, holistic way based on best practices and current research. CIR was selected for its robust connections throughout California.

This collaborative team was awarded \$200,000 in grant funds from the Office of the California Surgeon General (CA-OSG) and the Department of Health Care Services (DHCS) to participate in the state's ACEs Aware initiative. The team of collaborators was to conduct CALIFORNIA ACES ACADEMY (CAA), promoting the ACEs Aware initiative with Medi-Cal providers and others in 5 regions of California. CAA included an independent program evaluation.

### Mission & Vision

“We seek to inspire and educate healthcare providers to start ACEs conversations with their patients and their communities, so as to enhance their health and well-being,”

-Tasneem Ismailji, MD, MPH - co-leader of the CALIFORNIA ACES ACADEMY for the AVA, developer of the Regional Academy model.



## CALIFORNIA ACES ACADEMY GOALS & METHODS

1. To educate Medi-Cal providers and others about the value to themselves and to their patients of integrating ACEs informed care.
2. To support and assist Medi-Cal providers and others to overcome fear and other barriers, including COVID-19, to implementing ACEs informed care.
3. To help Medi-Cal providers and others consolidate learning through participation in small regional learning collaboratives.
4. To facilitate Medi-Cal providers' connections to local mental health and other resources by establishing Networks of Care.

These goals will be accomplished by educating Medi-Cal providers about:

- a) Toxic impacts of ACEs on the brain and body, and the range of ACE related medical presentations.
- b) How integrating ACEs into medical practice can improve care and efficiency, increase patient satisfaction, lessen practitioner burnout, increase job satisfaction, and improve patient outcomes.
- c) Concrete steps for integrating ACEs conversations and screenings into their practices.
- d) Prevention of ACEs, assessing strengths, protective factors, fostering resilience and Positive Childhood Experiences.
- e) Local mental health and community resources.

## CALIFORNIA ACES ACADEMY GOALS & IMPACT OF COVID-19

With the global onset of the COVID-19 pandemic, much of how those in the helping professions deliver services, access support, connect with colleagues and receive continuing education was changed. At the onset of this pandemic, CAA had already begun program planning, and adjustments had to be made. In recognition of the need for support and the continuation of work under extreme circumstances, CAA was dedicated to continuing on with an adapted program. These changes included moving to an entirely web-based platform for event delivery. Although this was a departure from the original in-person events, the web-based platform allowed for attendees to participate in events from any location, and for the sustainable production of recorded webinars, which have been made available to view without cost. Additionally, creating sustainable On-Demand events provides accessibility to those who may have been otherwise unable to attend due to scheduling demands. Free CME/CE credit was available for all live and recorded webinars.



## SPEAKER SCHEDULE

**Dr. Vincent J. Felitti**

The Repressed Role of Adverse Childhood Experiences in Adult Well-being, Disease and Social Functioning: *Turning gold into lead*

**Dr. R.J. Gillespie**

Parental ACEs and Pediatrics: Transforming Well Care

**Dr. Susie Wiet**

Addiction Born Out of ACEs and the Return of Hope

**Dr. Brooks Keeshin**

A Practical Approach to Deciding the Next Right Step for Trauma Exposed Youth: The Pediatric Traumatic Stress Care Process Model

**Dr. Megan Gerber**

Trauma-informed Care in the COVID-19 Era: ACEs, Telehealth and Beyond

**Dr. Leena Singh, Dr. Rachel Gilgoff, Ms.Lacie Ketelhut and Dr. Victoria Sparks**

What Happens After ACEs Screening? Effective Clinical Response and Community Partnership

**Dr. Bart Klika, Dr. Randell Alexander, and Victor Vieth,JD**

The Power of Preventing ACEs

**Dr. Robert Sege**

HOPE: Healthy Outcomes from Positive Experiences

**Dr. Martina Jelley, Dr. Julie Miller-Cribbs, and Dr. Fran Wen**

Using Simulation to Teach Adverse Childhood Experiences and Trauma-Informed Care

**Dr. Sharon Cooper**

Medical Advocacy in the Face of Discrimination

**Dr. Baraka Floyd and Dr. Robert Sege**

Balancing ACEs with HOPE (Healthy Outcomes from Positive Experiences)\*

\* Registration data available only at time of report



## ORIGINAL EVALUATION PLAN AND METHODS

### Registration and Evaluation Components

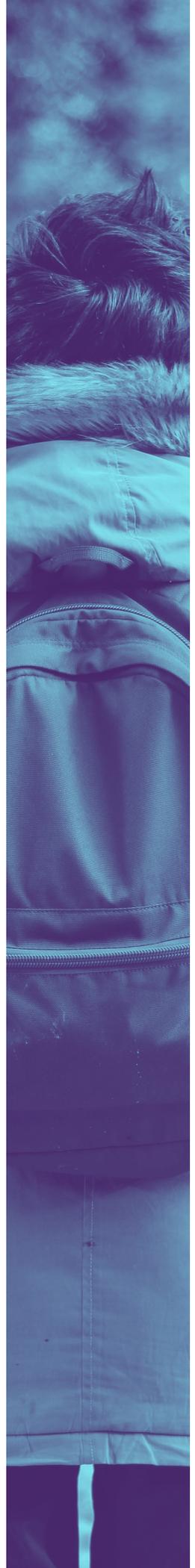
- Preliminary demographic and practice data from the registration
- Evaluation questions via link to confirm CME/CE credit for various professions
- ACEs Community Registration
- Focus Group
  - Frequency/Increment TBD
    - Mid-Course to allow for program accommodation for both monthly presentations and regional conferences
    - One focus group per region at mid-course
- Stakeholder debrief following program delivery to explore what worked and could be different
- Gather chat feedback from any web-based sessions held; summarize and return to program designers as available
- Relationships developed as part of participation in the process
- Participant ID numbers- track frequency, attendance, contact hours

### Deliverables:

- Interim data briefs to inform next steps
- Summary report of all data collected
- Final Project Report - Due 2 months post-program completion

### Potential evaluation questions to explore -

- Effectiveness of program delivery structure vs. existing training structures
- Increased ability to identify adversity
- Increased awareness of referral sources and processes
- Engagement in Learning Collaborative and Communities of Care
- Presentation content applicability to the job
- The usefulness of combined National & Regional Structures
- Intended behavioral changes



## CALIFORNIA ACES ACADEMY EVALUATION METHODS

Along with the program delivery changes which occurred as the result of the pandemic, evaluation processes were revised. These changes included a fully online data collection method, tethered to registration and CME/CE attainment, and/or sent to all confirmed attendees.

In an attempt to collect as much data as possible, full evaluation was split between registration and evaluation in an attempt to reduce the attrition of data due to the nature of lower evaluation response rates. This did result in an expanded registration process, but served to capture useful information about attendees. Registration and evaluation forms were revised multiple times throughout the process as the result of grantor requirements. The revision of speaker-specific learning objectives was anticipated, but the evolving nature of required registration and evaluation questions may negatively impact the quality of data. For example, the omission of a "not applicable" option on items specific to practice does not fully represent the interprofessional nature of diverse attendees or anticipate their potential responses.

### Registration and Evaluation Components

- Demographics- Location, race, sex, education, licensure.
- Practice Details- Screening practices, practice setting, practice specialty, occupation/provider type, caseload.
- Interest- Motivating factors for attendance, participation in other events.
- Effectiveness of Presentation- Knowledge, delivery, utility.
- Learning Objectives- Speaker-specific learning objectives as approved by CME/CE accrediting.
- Motivation to Change- The impact of each session to motivate changes in practice behavior, intended practice behavior changes, and perceived barriers to change.
- General Feedback- Larger programmatic and scope, and speaker-specific feedback.



## REGISTRATION OVERVIEW

### ATTENDEES AT A GLANCE

The total number of unique individuals registered for any event was 3956. A large majority of participants in the many sessions offered by CAA were female (Figure 1.). While the majority of participants (58%) were white, there was also a great diversity of other races represented (Figure 2.).

More participants were from the United States (96.3%) with all 50 states represented in the participant pool. Interestingly, more than half of the participants (54.3%) were from other states while Californians comprised 42.2%. The remaining 3.6% were from 34 other countries (Figure 3.).

Because the focus of CAA was on the state of California, it should be noted that 53 of the 58 counties were represented (missing counties: Alpine, Mono, Nevada, Sierra, and Tehama). Counties with the largest portion of participants include: Santa Clara (14.1%), Los Angeles (14.0%), Sacramento (6.5%), San Diego (5.8%), Fresno (4.1%), San Joaquin (3.8%), Alameda (3.2%), San Bernardino (3.1%), and Santa Barbara (3.1%). All remaining counties were less than 3%.

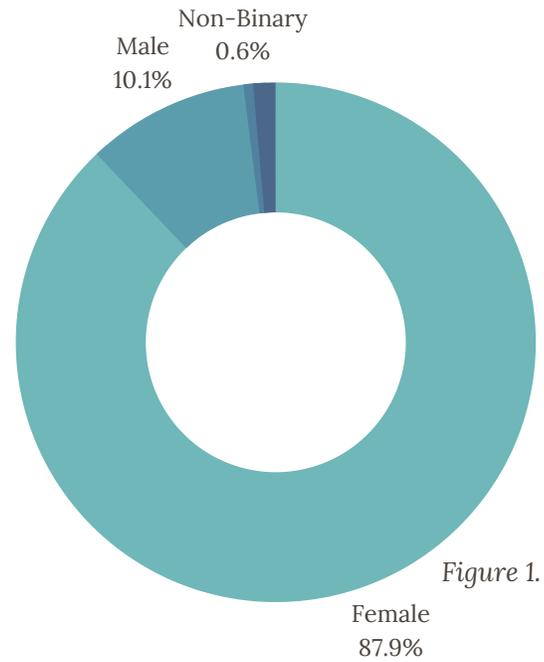


Figure 1. Sex

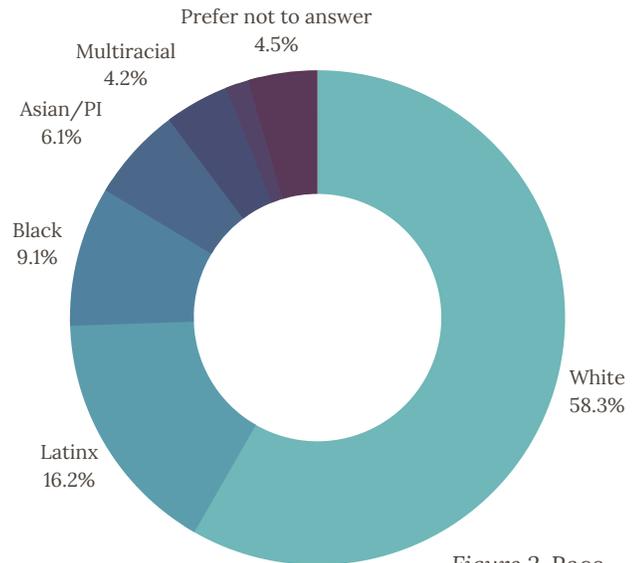


Figure 2. Race

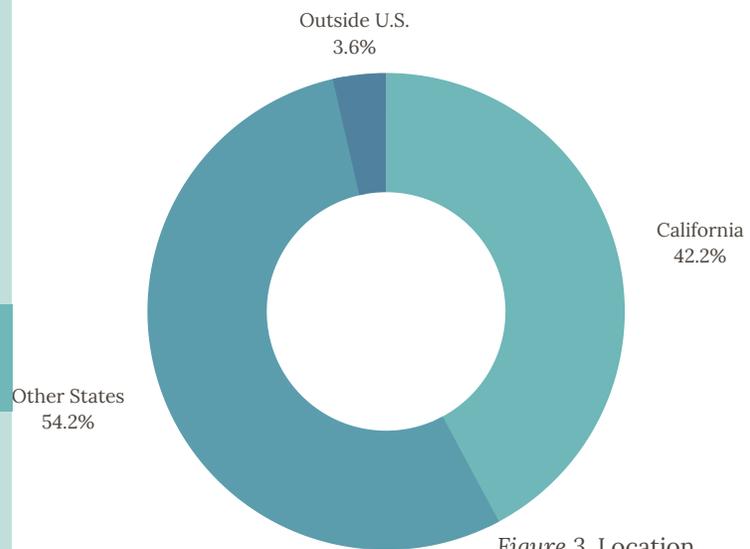


Figure 3. Location

### Top 3 CA Counties

14.1%

Santa Clara

14%

Los Angeles

6.5%

Sacramento

# REGISTRATION OVERVIEW

## ATTENDEES AT A GLANCE

### Education

The diversity in CAA participants is reflected in the variety of degrees reported in registration. Registrants were asked, “**What degree best describes you?**” The degree distribution of the 3712 people who answered this question is shown in Figure 4.

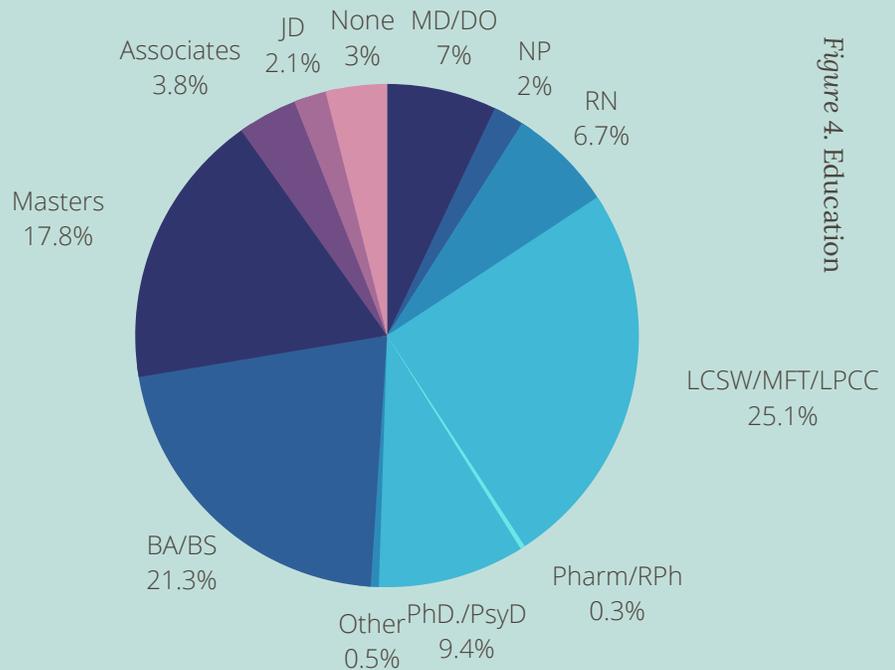


Figure 4. Education

### Specialization

Another reflection of the diversity of respondents is reflected in the areas of specialization. Of the 3844 individuals who responded to this question, **just over half (53.7%) indicated they were "not a clinician."** A majority of those who do identify as a clinician noted their specialization as behavioral health (including social work) shown in Figure 5.

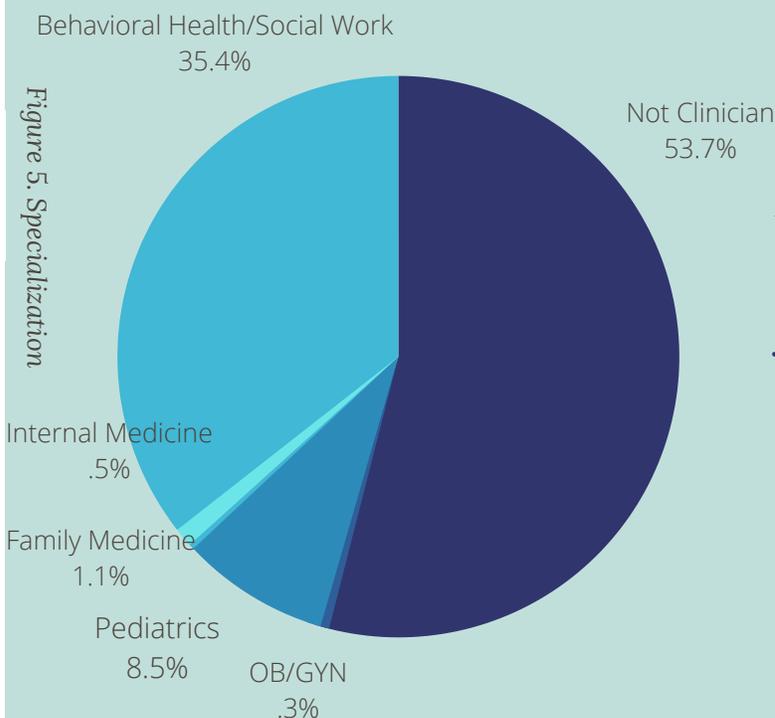


Figure 5. Specialization

# REGISTRATION OVERVIEW

## ATTENDEES AT A GLANCE

### Practice Setting

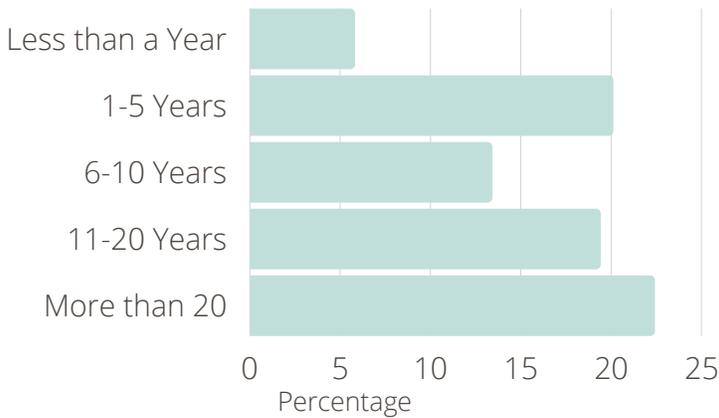
The diversity of the individual CAA registrants is reflected in the diversity of the settings, size, and focus of the practice for each registrant.

When asked, “Which of the following best describes your primary practice setting?” just over one-third (35.1%) reported working in the non-profit/community setting. The second most common setting was in government (20.9%). Interestingly, 13.4% said they do not actively practice. See Table 1.

Table 1. Practice Setting

None	.3%
Solo Practice	4.8%
Group Practice	3.5%
Government	20.9%
University/Teaching System	9.3%
Community Hospital	5.6%
HMO/Managed Care	1.0%
Non-Profit/Community	35.1%
K-12 Schools	1.7%
Multiple Settings	.3%
Non-Practicing	13.4%
Other	3.9%

Figure 6. Years in Practice



### Time in Practice

Respondents were also asked to note how long they had been in practice. Nearly one-fifth (18.9%) indicated the question was not applicable, perhaps indicating they did not see themselves as being in “practice.” CAA registrants generally come with a strong practice history--**41.8% have been practicing for more than 10 years.** See Figure 6.

### Caseload

When asked about the number of patients/clients seen each week, nearly half the respondents (48.3%) indicated they do not provide direct patient/client care. As can be seen in Figure 7, 47.1% of respondents see fewer than 50 patients/clients per week. This is consistent with the high portion of behavioral health providers whose caseload is typically lower than other types of clinicians.

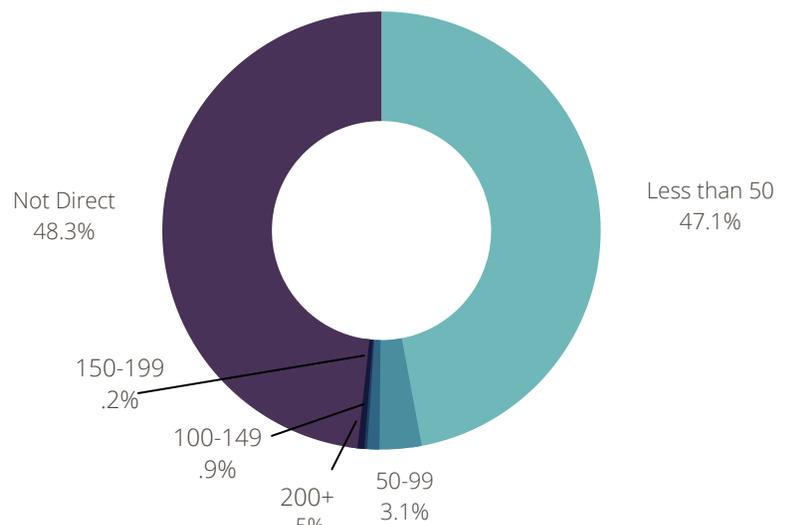


Figure 7. Patients per Week

The CAA management team was very interested in learning more about those who made the effort to register for one or more of the CAA webinars. *Table 2* provides data relating registration to the different types of webinars, webinar participation, and status as a Medi-Cal provider.

Of these 3956 registrants, 716 (18.1%) individuals noted they are Medi-Cal providers. Of these 716, 491 actually attended a webinar. These 491 Medi-Cal providers attended a total of 745 live and on-demand webinars. *See Table 2*. The total number of registrations for the live and on-demand webinars was 6291. The cumulative total of events attended by any participant was 3991. *See Table 3*.

Over the course of CAA, a total of 6291 separate registrations were completed. From this, participants engaged in a total of 3991 individual webinars. This reflects a 63% overall participation rate.

As seen in *Table 3*, Dr. Vincent Felitti started off CAA and was a great draw. His webinar attracted 1422 registrants, with 1013 attending, a 71% participation rate. Figures for all webinars are presented in *Table 3*.

**Table 2. Registration Data Summary**

	Data Report 1 N = 2621	Data Report 2 N = 1065	Data Report 3 N = 1061	Total
Total number of unique individuals registering for any session during this period	2621	749 – New 316 - returners	630 – New 431 - returners	3956
Registered only for live sessions	2286 (87.2%)	924 (86.8%)	950 (89.5%)	3474 (87.8%)
Registered only for On-demand sessions	218 (8.3%)	103 (9.7%)	28 (2.6%)	314 (7.9%)
Registered for both	117 (4.5%)	38 (3.6%)	83 (7.8%)	168 (4.2%)
Participated in one or more session	1757 (67.0%)	705 (66.2%)	704 (66.4%)	2590 (65.5%)
Registered but did not participate in any session	864 (33.0%)	360 (33.8%)	357 (33.6%)	1366 (34.5%)
Registrants who noted they are Medi-Cal providers	431 (16.4%)	222 (20.8%)	201 (18.9%)	716 (18.1%)
Medi-cal providers who attended one or more session	309	145	111	491
Medi-Cal providers attended				
Live	385	138	119	642
On-demand	65	27	5	97
Total	450	165	130	745 sessions

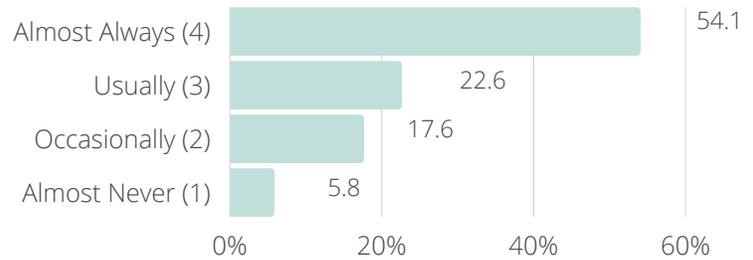
Table 3. Registration and Attendance by Presenter

Registration			Attendance				
		<b>Total</b>	<b>Attended Live</b>	<b>Report 1 On-Demand</b>	<b>Report 2 On-Demand</b>	<b>Report 3 On-Demand</b>	<b>Total Participants</b>
<b>Felitti</b>	Live	1117	708	203	73	29	1013 (71%)
	On-demand	305					
	Total	1422					
<b>Gillespie</b>	Live	484	326	30	23	8	387 (71%)
	On-demand	61					
	Total	545					
<b>Wiet</b>	Live	641	369	122	26	22	539 (66%)
	On-demand	170					
	Total	811					
<b>Keeshin</b>	Live	556	340	20	35	11	406 (65%)
	On-demand	66					
	Total	622					
<b>Gerber</b>	Live	477	285	12	33	5	335 (64%)
	On-demand	50					
	Total	527					
<b>After ACEs Panel</b>	Live	439	249	--	9	9	267 (54%)
	On-demand	57					
	Total	496					
<b>Prevent ACEs Panel</b>	Live	575	369	--	2	7	378 (65%)
	On-demand	9					
	Total	584					
<b>Sege</b>	Live	467	240	--	--	12	252 (53%)
	On-demand	12					
	Total	479					
<b>Simulation Panel</b>	Live	310	158	--	--	2	160 (51%)
	On-demand	2					
	Total	312					
<b>Cooper</b>	Live	262	125	--	--	0	125 (48%)
	On-demand	0					
	Total	262					
<b>Sege/Floyd</b>	Live	231	129	--	--	0	129 (56%)
	On-demand	0					
	Total	231					
<b>Totals</b>	Live	5559	3298	387	201	105	3991 (63%)
	On-demand	732					

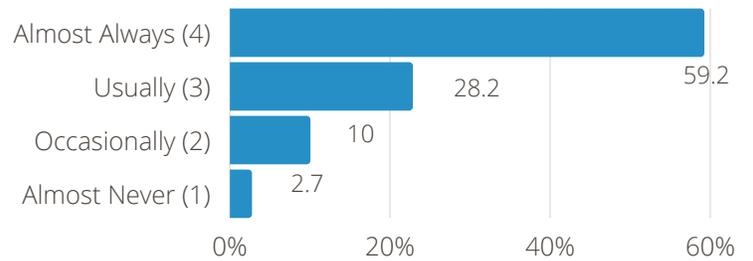
# REGISTRATION OVERVIEW

## ACEs, Practice, Attitudes, & Implementation

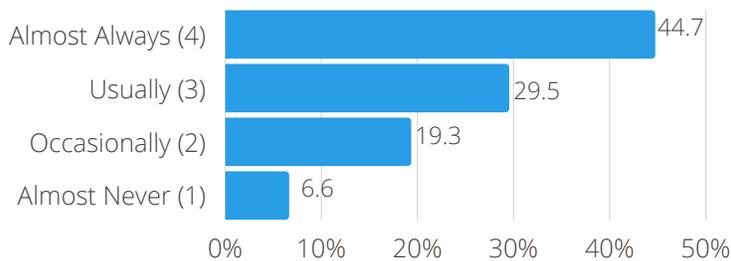
One of the primary purposes of CAA was to help clinicians understand the impact of childhood adversity on their patient/client's life and explore how this information could be gathered, discussed, and addressed in the clinical setting. The results of items 1-17 reflect the participants' level of engagement with the issue at the time of registration. These findings reflect those who responded to each question indicating it was applicable to their situation.



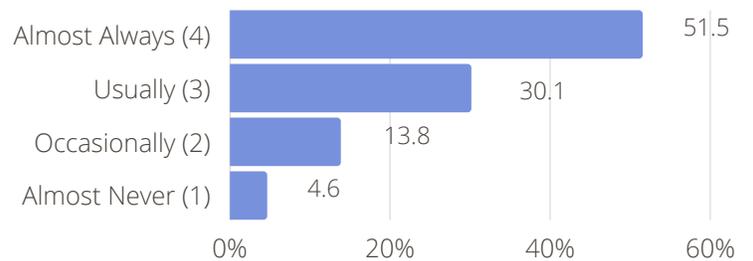
**Item 1.** How often do you ask your patients about experiences of childhood adversity? (n = 2279)



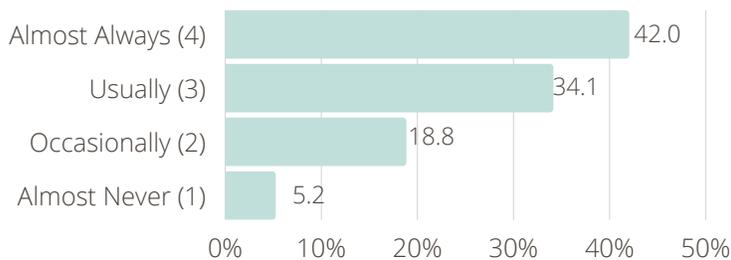
**Item 2.** I am able to explain the rationale for asking about childhood adversity. (n = 2440)



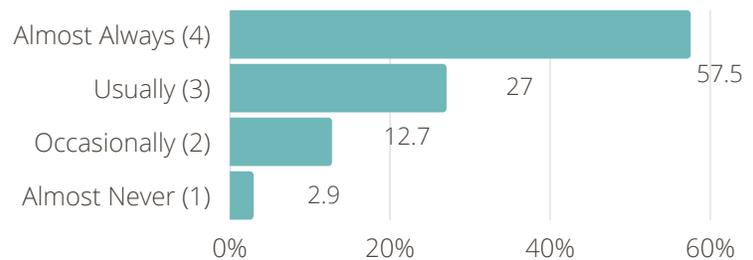
**Item 3.** I discuss the connection between current concerns and childhood adversity with my patients. (n = 2221)



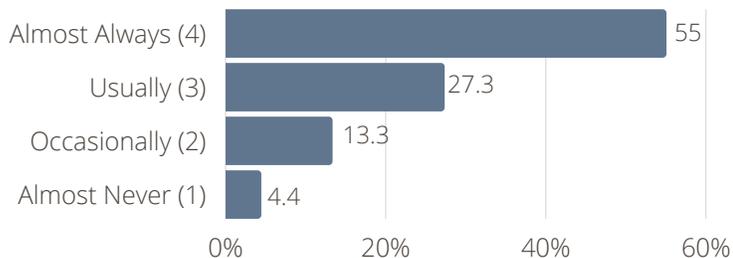
**Item 4.** I integrate my knowledge of the patient's childhood adversity history into our treatment plan. (n = 2089)



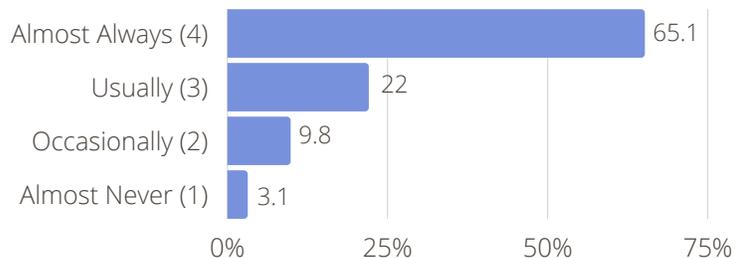
**Item 5.** I follow-up on issues related to childhood adversity during subsequent visits. (n = 2026)



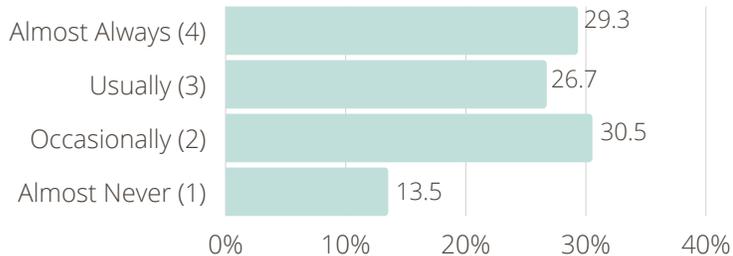
**Item 6.** How often do you talk about strengths, protective factors and resilience with your patients? (n = 2362)



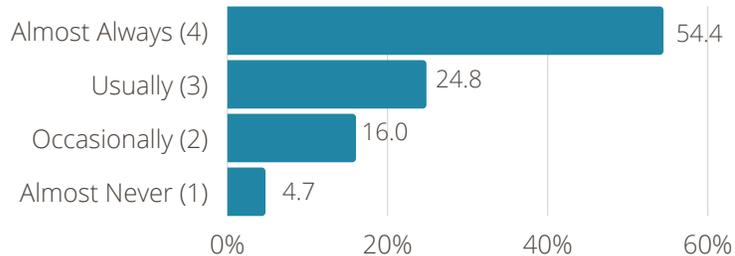
**Item 7.** How often do you include strengths and resilience-building activities in treatment plans? (n = 2142)



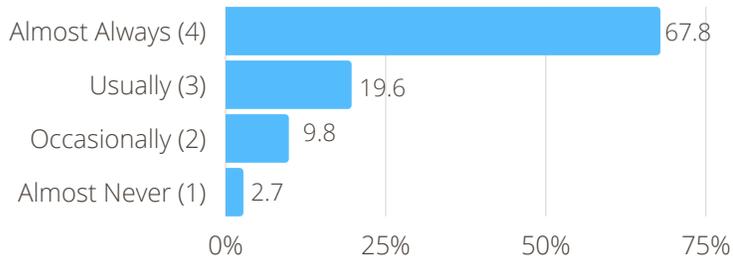
**Item 8.** I ask my patients about current violence or trauma disclosed by a patient. (n = 2279)



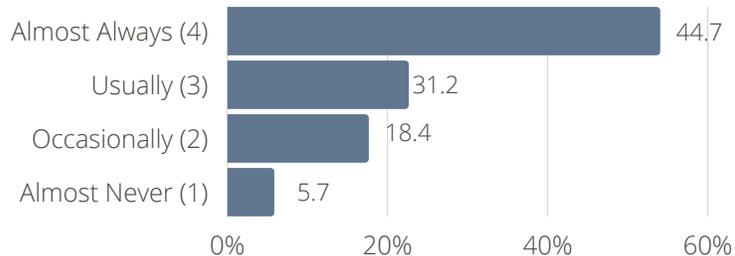
**Item 9.** I discuss community-based and historical trauma with my patients. (n = 2251)



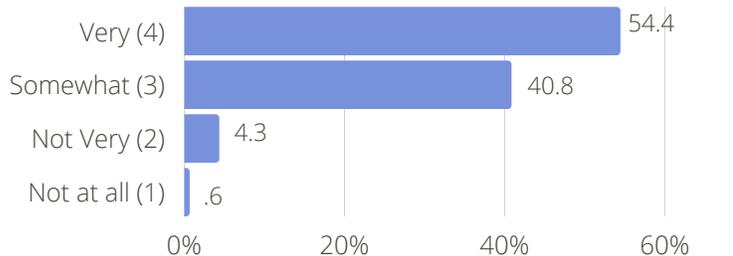
**Item 10.** How often do you assess for or ask a patient about their history of potentially traumatic events? (n = 2300)



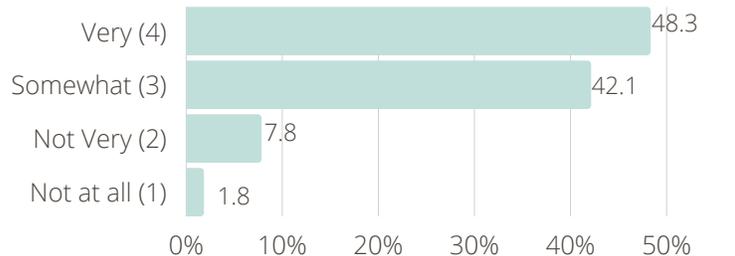
**Item 11.** How often do you provide resources for patients who disclose they are experiencing violence or suffering from a traumatic event? (n = 2388)



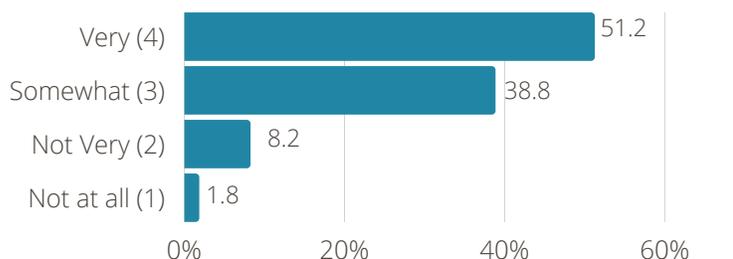
**Item 12.** How often do you ask your patients about the impact of COVID-19 on their emotional well-being? (n = 2311)



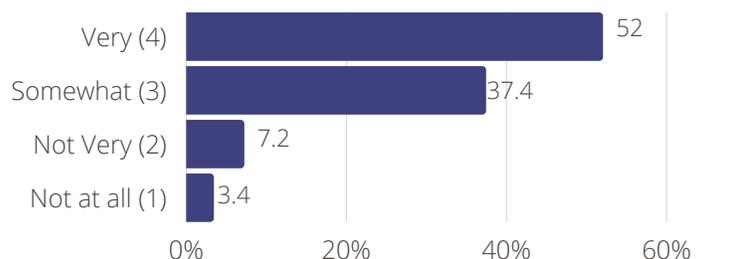
**Item 13.** How familiar are you with the relationship between childhood adversity (or other toxic stressors) and physical health / general wellbeing? (n = 3249)



**Item 14.** How familiar are you with the concept of intergenerational trauma? (n = 3297)



**Item 15.** How familiar are you with the relationship between childhood adversity (or other toxic stressors) and physical health / general wellbeing? (n = 3249)

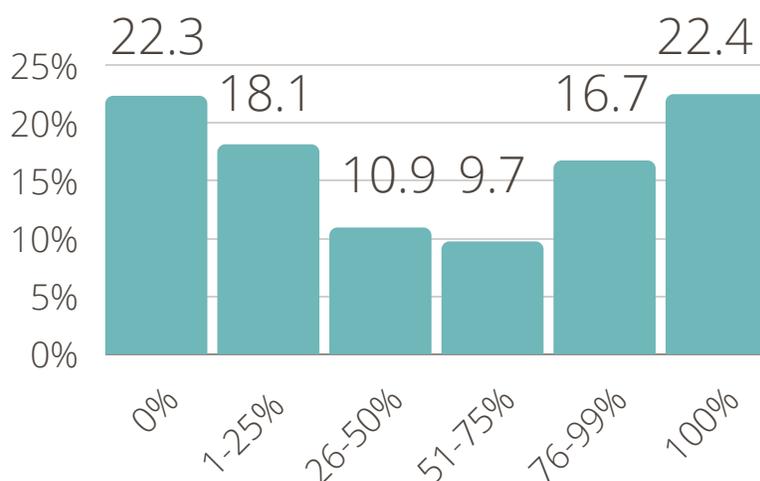


**Item 16.** How familiar are you with the Adverse Childhood Experiences (ACEs) Study? (n = 3330)

# REGISTRATION OVERVIEW

## ACEs, Practice, Attitudes, & Implementation

As has been evident in the data, not all respondents work directly with patients/clients. When asked “What percentage of your patients do you currently screen for ACEs?” just under half (48.4%) provided a response that indicated they work directly with a population. Of those who do work with patients/clients, there is quite a mix of practices relative to screening for ACEs. This question is similar to the above items and gives numerical context to the Likert scale answers in that question. Interestingly, approximately the same percentage of respondents reported screening 100% of the patients as did those who reported screening 0% of their patients (22%).



**Item 17.** What percentage of your patients do you currently screen for ACEs? (N=1916)

Of particular note, there is a visible difference in trends in the above-mentioned items and item #9. This is highlighted here as desires for education about how to discuss issues of race and diversity were identified as a major theme in evaluation qualitative data as will be discussed.

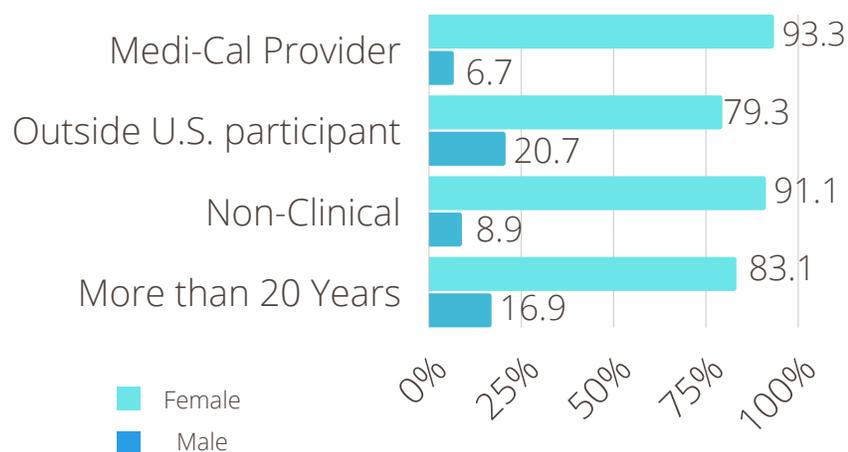
## Registration: Within Group Comparisons

The possibilities for comparisons between different groups within this large data set are almost limitless. The challenge is to identify areas for comparison that might provide information to help better understand the findings and for designing future programs.

Given this focus, analysis of registration data (and where possible, evaluation data) include comparisons between participants' sex, race, location, Medi-Cal provider status, direct care provider status, and length of time in practice. Comparisons will also be made based on CAA participation and evaluation completion status. This will determine if the data can be extrapolated to non-participants and non-evaluation completers.

### Demographics: Sex

As noted on page 6, the registrants for CAA were largely female (87.9%). As shown in the figure to the right, significant differences relative to a registrant's sex can be noted. Medi-Cal providers and those identifying as non-clinical participants were statistically more likely to be female. On the other hand, participants from outside the U.S. and those who had been in practice more than 20 years were statistically more likely to be male.



Educational differences were found as those with PhD/PsyD. and MD/DO degrees were more likely to be male; while NPs, RNs and LCSWs were disproportionately female. Males were more likely to report "Internal Medicine" as their specialization while 100% of Ob/Gyns were female.

Interestingly, females were more likely to work in the HMO/managed care setting while more males engaged in solo or group practice. Patient/client caseloads also differed as females were statistically more likely to report "less than 50" as the caseload size. As the caseload size increased, the portion of males with larger caseloads increased.

Attitude/Practice Questions: The only question where a significant difference was found was #11. Females are more likely to provide resources to clients when DV is reported. While the difference was statistically significant, it was too small to be considered practically significant.

# A CLOSER LOOK: RACE

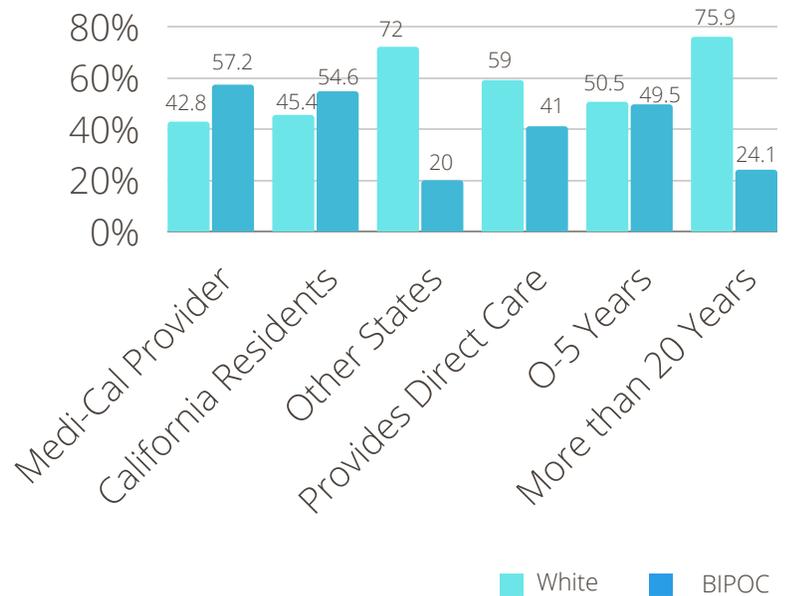
## Registration: Within Group

### Comparisons

Evaluating the findings relative to race provided some interesting data. Recall that the overall population is 58.3% White and 41.7% BIPOC. Medi-Cal providers were significantly more likely to be People of Color as were California residents, providers of direct care, and those newest to their profession. Respondents from other states and those with 20+ years in the field were more likely to be White.

In addition, People of Color were more likely to report Pharm/RPh, associates or no degree. Whites reported significantly more Pa/A-C, NP, RN, and JD degrees. Whites were also over-represented in internal medicine and Family medicine. In the work setting, People of Color were more likely to work in an HMO/Managed care or non-profit/community settings while Whites were more likely to work in a solo or group practice or in a university or teaching setting.

Demographics: Race



While most respondents either had caseloads under 50 or did not provide direct care, Whites were more likely to have mid-range caseloads (100 - 200) while People of Color were more likely to have large caseloads (200+). In general, People of Color reported screening for ACEs less frequently than Whites. Interestingly, People of Color were significantly more likely to be Medi-Cal providers and more likely to provide direct care.

Attitude/Practice Questions: For each of the questions on pages 11 and 12, Whites were more likely to engage in the particular practice described than BIPOC respondents. Statistical differences were found in all questions except questions #9 and #12. Again, while differences were statistically different, they were not practically different.

# A CLOSER LOOK: LOCATION

## Registration: Within Group Comparisons

It was very interesting to learn that more than half of registrants (57.9%) for the CALIFORNIA ACES ACADEMY came from outside the state of California. Registrants from other U.S. states were less likely to be actively practicing. Those from outside the country were more likely to provide direct care and also much more likely to have worked 20+ years in the field.

	<b>California</b> 42.2%	<b>Other U.S. States</b> 54.3%	<b>Global</b> 3.6%
<b>Do not actively practice</b> ( $p<.001$ )	37.5%	60.1%	2.4%
<b>Provides direct care</b> ( $p<.001$ )	41.1%	54.1%	4.8%
<b>More than 20 years in practice</b> ( $p<.001$ )	32.8%	60.3%	7.1%

California-based participants were more likely to have degrees including PA/PA-C, Pharm/RPh, Associates, or none. Those from other states disproportionately reported degrees as NP, LCSW, and JDs. Those from outside the U.S. had a higher proportion of MD/DO, Ph.D./PsyD, and Master's Degrees.

A higher proportion of Pediatricians and family medicine doctors came from outside California.

Those from California were also more likely to work in government, HMO/Managed Care or non-profit/community settings. Those from another U.S. state were more likely to practice in a solo or group setting, University/teaching system, or community hospitals. Those from outside the U.S. were more likely to work in solo practice, University/teaching system, or community hospitals and those from U.S. states outside of CA were most likely to screen patients for ACEs.

Attitude/Practice Questions: Responses to questions 1-3, all related to asking patients/clients about childhood adversity, were significantly lower in California than in both other states and outside the U.S. For questions 4, 10, and 13-17, the responses of Californians were significantly lower than those from outside the U.S.

# A CLOSER LOOK

## Registration: Within Group Comparisons

### Medi-Cal Providers

For this analysis, only the 1668 respondents from California were included. As might be expected, those who report being Medi-Cal providers are more likely to provide direct care to patients/clients. Medi-Cal providers were more likely to screen for ACES than non-Medi-Cal providers.

Medi-Cal providers were more likely to have medical degrees such as MD/DO, PA/PA-C, NP, RNs, and LCSW/MFT/LPCCs. Those with academic degrees at their highest level of education, such as Bachelors, and Pharm/RPh were less likely to be Medi-Cal providers. Also, those with a degree in another field (JD), no degree, or an unknown degree were less likely to be Medi-Cal providers.

Areas of specialization associated with being a Medi-Cal provider included Pediatricians, Ob/Gyn, and Family Medicine Doctors. Those practicing internal medicine or who were not clinicians were significantly less likely to be Medi-Cal providers.

Practice settings are also very different for Medi-Cal versus non-Medi-Cal providers. Medi-Cal providers tend to work in a group practice, community hospitals, HMO/managed care, and non-profit/community settings. Non-Medi-Cal providers are more likely to work in solo practice, government, and both K-12 and university educational institutions.

Attitude/Practice Questions: It is interesting to note that Medi-Cal providers are more likely to ask patients/clients about current violence or trauma (#8) or about the impact of COVID-19 on their current situation. (#12).

### Direct Care Practice

As reported with Medi-Cal providers, those with practice-related degrees (MD/DO, PA/PA-C, NP, RN, LCSW/MFT/LPCC) were more likely to report engaging in direct practice. Interestingly, those with Associate degrees were also more likely to provide direct care. Bachelor's, Master's and JD level graduates and those without a degree or an unknown degree were less likely to provide direct care.

Regarding areas of specialization, those who did not identify as a clinician were significantly more likely to report not providing direct care. However, this was not true of ALL non-clinicians as 37.8% of non-clinicians did report providing direct care, just not at the clinical level. The most common practice setting for those not providing direct care was within the government setting.

Attitude/Practice Questions: It is understandable that responses to this question set would vary significantly between those who do and those who do not provide direct care and many of the questions are relevant only to the direct care setting. Significant differences were found with questions: 1-3, 8, 10, 11, 13-16.

## Registration: Within Group Comparisons

### CAA PARTICIPANTS

As was noted, about one-third of those who registered for one or more sessions did not attend any session. When analyzed for differences between those who did and those who did not attend, no significant differences were found. This “non-finding” is important as it allows us to have more confidence that responses to evaluations could more likely represent what might have been reported by all registrants had they attended and completed an evaluation.

### TIME IN PRACTICE

The length of time a person has been in practice can have a significant impact on their attitudes toward practice principles, new learning, and practice activities. The original 5 time frames for practice were collapsed into three for analysis. These included: 1) Less than a year through 5 years (34.2%); 2) 6 - 20 years (43.6%); and 3) 20+ years (22.2%).

Those with degrees including MD/DO, RN, and PhD/PsyD were more likely to have 20+ years of practice. The LCSW/MFT/LPCC and JDs were more likely to have been in practice 6 - 20 years. Those with a PA/PA-C, Pharm/RPh, Bachelor's or Associate's degree were most likely to have been in practice 5 years or less. The practice settings were also correlated with length of time in practice as those in solo practice and the University/teaching setting were more likely to have been in practice 20+ years. Those working in a government or HMO/Managed care setting were more likely to have been in practice 6 - 20 years. Those in a non-profit/community setting were more likely to have been in practice 0 - 5 years. Practice size was also somewhat related to length of practice as those with fewer years in practice tended to have smaller caseloads. There was a relationship between length of time in practice and percentage of patients/clients currently being screened for ACEs as the longer one was in practice the more likely they were to screen more often.

Attitude/Practice Questions: The practice questions reveal a very interesting trend. For most of the questions, the length of practice is significantly linked to the practice activities evaluated. That is, the longer one is in practice the more likely they are to engage in the activity. This was true for questions 1-5, 8, and 13-17. For questions 6 and 9-12, the 0-5 yrs group was significantly less than the 6 - 20 yrs and 20+ yrs groups. Only question 7 showed no difference between the three groups. Again, the differences were significant but not practically different. However, the trend is clear and worth noting.

## REGISTRATION QUALITATIVE DATA

The final portion of the registration asked two open-ended questions. Responses to these questions provide more depth on attitudes and perspectives CAA registrants brought to the webinar sessions prior to participation. It is important to remember that these open-ended questions were only answered the first time an individual registered for a CAA session. If the person noted they had already registered for CAA, these questions were not asked again.

### OPEN-ENDED QUESTION ONE

The first open-ended question asked, “What is your typical next step when a patient discloses that they are experiencing violence or suffering from a traumatic event?” There were more than 2000 responses to this question. A simple word search provides an overall view of the primary themes of responses to this question.

When scanning for most commonly used words, the term “refer” (which could also be short for referral or referrals) was mentioned 795 times, and resource/resources was used 726 times. These terms were generally associated with providing patients/clients with information on how to address immediate needs or situations. The most common referral mentioned was to mental health therapy. Other common referrals included medical care, domestic violence services, housing, or a general referral for additional resources. Referrals regarding violence involving children often included connecting with and making reports to child protective services as required for mandated reporters.

An additional commonly used word (462 times) was “assess.” This term was often modified by the type of assessment indicated such as assess for suicidality, safety and safety planning, the risk to self or others, and other such issues. Other terms that occurred frequently include: validate, discuss, listen, screening, support, evaluate, consult, acknowledge, normalize, and ask questions.

In addition to common terms, the perspective or tone of some responses reflects the provider's view on the relationship. Some responses had a more partnering tone while others were more directive in nature. Examples of a more provider directed comment include:

- *Help them find resources. Teach them somatic stress reduction tools, such as EFT/Tapping, Emotion, and Body Code. Teach them about neuroplasticity and the polyvagal theory. Help them release over activation so they can make good decisions about their life.*
- *I use an unexpected excited response that temporarily shocks the patient's mind. This disrupts their emotional path and confuses the patient, as the patient was expecting sympathy or empathy.*

Examples of providers working in a more patient/client directed manner include:

- *I would validate their concerns, ask questions specific to contemporaneous risk to self, children, vulnerable adults. If a patient is disinclined to accept assistance and is not himself or herself a danger to themselves, then people are entitled to their choices. I would continue to be non-judgement and communicate the offer of assistance at any time in the future when the client is ready to accept the help and support. I would raise the topic at every meeting I had with that person in the future.*
- *Thank them for disclosing. Safety planning. Let them know they are not alone and there is help and support in our community. Discuss ways trauma can affect our minds and bodies. Talk about opportunities for the future and the direction they would like to go from here.*
- *Almost all youth and family referred to me have been assessed by a mental health provider and need my support because they are suffering from reasons associated with ACEs. My responsibility is to advocate and provide peer support for those areas of most immediate concern--determined by the youth or family.*

Recall that the population of registrants included a large group (35.4%) who identified as behavioral health professionals and 53.7% who identified as non-clinical. However, the language in the registration form consistently referenced “patients.” This resulted in many respondents simply noting that they do not have “patients” and marking N/A on these questions as one respondent said: I am in the legal field and we use ACEs in the specialization that I do. Trauma informs the circumstances of our clients and the outcomes of their cases. I marked n/a on anything that said "patient" because I have "clients" not patients.

Other respondents provided interesting insights into how they reframed the material to fit their professional situation.

- *As a social service supervisor, I do not have “patients” as a doctor does, but our clients all have high ACE scores and I use that knowledge daily to assess their needs and the appropriate services for them. I also use this with my staff to ensure they are mindful of the relationship between the ACE and the current functioning. When disclosure takes place, the child/client is linked to the most appropriate services we have very quickly.*
- *As a capital mitigation specialist I do not provide treatment and I am in the role of information gathering. My clients are incarcerated and I have little control over what happens to them, but I work with the lawyers to advocate for their safety if they are experiencing violence or in danger. I listen, empathize, try to validate, and also not re-traumatize my clients by asking too many questions about the traumatic event. I work on grounding with them and try to help them think through ways to be safe as much as they possibly can.*
- *I am a volunteer advocate for foster youth so I do not see "patients". However, when my assigned youth are experience violence or traumatic events I can be there to support them as well as ensure that they have access to professional services (ie. therapy).*

- *We serve callers, not patients. But they are often the same people. If we are not on the same page, healthcare, behavioral health and social services, we are missing crucial connections. I do not have to be a physician to understand and utilize knowledge of ACES and how to respond in an appropriate way that moves a person toward healing. Callers to the 2-1-1 helplines are often seeking help for the first time. 211 staff can and should be the front door to a better life for people seeking help. I want my staff to be highly trained on the effects of ACES. And I want for us to incorporate protocols that are informed and appropriate so we can be part of the solution.*
- *In an emergency medicine setting, I ensure that the pt is stable for transport. We have long transport time which provides for an opportunity to converse with patients if they are open. I work with local law enforcement to determine if an advocate is appropriate and help to provide resources.*

## OPEN-ENDED QUESTION TWO

The second open-ended question asked, “What drew you to participate in this ACADEMY?” More than 3400 individuals responded to this question. The answers reflected a variety of interpretations of the question. Some respondents spoke to their interest in participating in the ACADEMY as a whole, others spoke to the draw of the particular webinar for which they were registering and a few spoke to the literal mechanism by which they learned about and registered for the webinar. Analysis of the responses will be done in two phases to reflect this variety of answers.

When reviewing comments related to CAA as a whole, another simple word search revealed basic trends in common responses. The group commenting literally on what brought them to CAA spoke of receiving an email (157), that someone they respected suggested attending or that it was recommended/required by a supervisor or program director. Another set of respondents were specifically drawn because the course was related to ACEs (1434). Comments focused on the desire to continue learning (740), develop knowledge (326) or increase understanding (261). There is a strong feeling that ACEs are a subject of interest (635) to many.

The group commenting on the ACADEMY as a whole often spoke of the general value of being trauma-informed and/or being informed by the findings of the ACEs Study. The general hope was that the ACADEMY sessions would continue the growth process. As respondents noted:

- *In my work to educate, aggregate, engage, activate and celebrate ACEs education and establishing trauma informed practices and principles throughout the Southeastern U.S., I need all the resources, information, help I can secure. This series is excellent and will be a tremendous help in my looking to replicate it in other states. ACEsAware Campaign is fabulous. Needs to be national.*

- Throughout my life and my work I have watched and felt individuals who are suffering from their trauma experience and have always sought out the most up to date treatment modalities to help people heal. I think there is more to learn and embrace about this experience. It is a journey.
- *The understanding that adversity and trauma (even significant repetitive unregulated stress) have lifelong health and well-being implications. In fact, I feel it is more destructive to our world than any infectious disease pandemic. I am looking for practical ways to apply in setting with limited resources and psychological supports (most people don't have money and/or time to engage in ongoing structured therapy).*
- I have a family I have been working with over the past 4 years. The mother and children have suffered long-term, ongoing emotional abuse from the father. The legal and protective services are not adequately trauma-informed. This week the Family Court Commissioner again mandated joint decision making in the parenting plan. My client has chronic, severe PTSD from this man and he plays the system and his family with skillful cruelty. I am motivated to see what I can do to get Washington State to consider verbal/emotional abuse with the same seriousness as physical and sexual abuse.
- *I have an ACE score of 9 and see how little to no knowledge of ACE's throughout my life by myself, health practitioners, and anyone around me, has affected my own life and health trajectory and how important it is to get the word out about it and change how so many aspects of health education and support can change for the good as a result. Note--I answered the above questions with the word 'patient' functioning as 'community member' - since I work with community members but not in a practitioner-patient relationship.*

The final group of respondents spoke directly to what they hoped to receive from the particular webinar for which they were registering. Again, respondents only answered this question the first time they registered for a CAA activity. This resulted in receiving more than 1/3 of the comments during registration for the first webinar, Dr. Vincent Felitti. As the ACADEMY continued, fewer and fewer registrants were new to the ACADEMY and so most did not receive this question again. A sample of the comments specifically relevant to each speaker/topic is presented here.

### **Webinar 1: Dr Vincent J. Felitti, MD**

- I have been impressed by the ACES study since I learned about it. It is very powerful evidence of the long-term effects of trauma and really helps my clients understand the origins of their distress and make sense of their symptoms, without demonizing themselves. I am always looking for more support, more tools to share with my clients to improve their prognosis for healing.
- *I have always been interested in ACES. I have spoken about ACES to my colleagues and the pediatric residents who rotate in the protection center. I want to know more about it to help me in my advocacy to tell pediatricians what ACES really signify.*

- *I learned a great deal about ACEs in 2008 while provider direct care in the child and youth system of care. I transitioned into the adult system of care and witnessed the impact of ACEs on adult functioning. I am now a Triwest CCN provider for veterans. Very often veterans have experienced ACEs and then traumatic military experiences. It's important to continue my growth in this area so I can continue to educate those I serve.*
- *The ACE Study is the result of counterintuitive findings related to successful weight loss in the Obesity Program in my Department. I am now retired after 50 years practice and want to review my ACE presentation to see how it might be improved.*
- *I want to understand ACEs better since I work in the criminal legal system and have the opportunity to explain the impact of trauma to legal system stakeholders on a regular basis.*
- *I am a law enforcement manager. I have spent the majority of my career working in a specialized unit that involves all aspects of family violence. My goal is to create some training/program for the police department so they can provide better service to the people they encounter that have been traumatized. The more they understand trauma and its effects the better they can do their job.*
- *I need to learn to incorporate ACEs into my daily prevention practice with the families I work with. To do this I need to learn how to screen for ACEs more effectively. I need to learn to talk about ACEs more effectively with the families so they can learn to be more resilient.*
- *Learning more specifically about the ACEs Study, the screening process, and how to incorporate this knowledge in my practice. Also, I have worked with clients and families in crisis who have experienced complex trauma (independently and intergenerationally) and I find that the more I can learn about helping a client manage, understand, and heal from trauma, the better practitioner I can be to support my own clients and my colleagues too.*
- *My deep passion, connection and concern for the children and families that I work with. Most of my families are overburdened, under resources and stressed. I am committed to learning and staying informed so that I can continue to provide exceptional supports and services to children and families.*
- *My clients have often experienced nearly all of the ACEs. I have never attended a training or educational session specifically on this topic. I have learned about it through my work, but not through formal training. This is a wonderful opportunity to get a better understanding of the ACEs, especially resiliency, which is something that I am not as familiar with.*
- *I want to learn more so that I can help change our broken system. I am a child abuse survivor, so is my child. Both of us have experienced great injustice and abuses (secondary traumas) directly related to the medical system and the public school system.*
- *I have been fascinated with the ACE study since I was in school. The more I work in the field of Capital Defense, the more I realize that my clients are like canaries in the coal mine: punished or sentenced to death as a result of the dysfunctional behavior and disorganized thinking that is a direct result of childhood trauma that, as a society, we don't protect them from, support their parents through, and sometimes we make it worse. I would like to be better able to verbalize the effects of ACEs when telling my clients' stories for the purpose of mitigating their sentences.*

- *I am a mitigation specialist so I don't provide direct care. My clients are those charged with capital crimes and face execution. The information I collect is to create a life history used in trial preparation and to appropriately identify necessary experts. Learning more about what to screen for and understanding ACES would be beneficial in my practice.*

Many of those registering for the webinar spoke of their basic knowledge of ACEs and were hoping to learn more on the topic, updated findings or new links that could be made from the ACEs Study. Some of these responses might suggest additional topics for Dr. Felitti or others to address in the future.

- *I am an ACE educator in Louisiana and director of a new non-profit made up of ACE educators wanting to build up our community. I also work in the school system as a full time social worker and am interested to hear Dr. Felitti speak to the current landscape facing our families.*
- *I am curious to see what updates if any there have been in relation to race, and how to adapt and how to considering the study consisted of 74.8% white individuals. Additionally, I am also curious how the body positive movements are being incorporated or thought of along with ACEs because its original focus was weight loss.*
- *Learning about ACEs and the work Dr. Felitti has done revolutionized the way I treat my patients with behavior problems and improved outcomes of many children. I am interested to hear what else he has learned about the impact of trauma on children and adults.*
- *Native communities often have high ACE scores. I am interested in understanding how that high score throughout the community can inform programming and how culturally attuned programming can encourage healing both individually and community wide.*
- *To learn more in detail about ACEs -To learn how to efficiently incorporate ACEs screening in a busy practice -Learn how to compassionately screen young children for ACEs -Learn how to compassionately discuss why I am screening their children for ACEs -Above everything else, my biggest hurdle in not wanting to screen these young children and families is the systems inability to provide services for these kids and their families. It's like why should I open this pandora's box if I am not going to be of any help!*
- *I am a pediatrician and very involved in my clinic's transformation to a Trauma-Informed and Resilience-Oriented (TIRO) health center. I have seen generational trauma in many different settings through the world and in my own family as a medical doctor and human being. I fully support the integration of healing the mind, body, and spirit and want to educate individuals but also the society at large in order to prevent and address the vicious, pervasive effects of ACEs now and to future generations.*
- *I've been studying ACEs and resilience more specifically for over 2 decades. I met you back in 1997 when you were 1st presenting on the ACEs study. I went back to school, earned a PhD in Clinical Psychology and did my dissertation on how trauma impacts resilience. I am interested in hearing how your presentation has changed & what you are doing now, as this body of work has grown into the most predictable social determinant of health across the lifespan. Your research has had a huge impact on my work & life. Thank you, K.B.*

### **Webinar 2: R.J. Gillespie, MD, MHPE, FAAP**

- I'm currently a CASA advocate's and could use what Dr. Gillespie is teaching about with Children to Adults and as well in our faith-based organization.
- *The title of this free webinar caught my attention. Although I do not provide clinical care, I teach in a College of Nursing that has systematically integrated ACEs & related concepts across BSN and MSN curricula.*
- I'm a pediatric RN and also PhD student interested in researching interventions to promote resiliency from adverse childhood experiences, and am particularly interested in the intersection of child abuse and IPV.
- *Very interested in breaking the cycle of ACES and educating parents in how their early experiences may change how they parent. Promoting resilience in families*
- The topic is interesting. I would like to learn different ways that health care organizations can help patients and their families who have stressors or have experienced trauma.

### **Webinar 3: Susie Wiet, MD**

- *I have many years of experience in the substance abuse field and have seen the direct correlation between ACES and addiction. In my experience, this is a topic that needs to be talked about more often. I'm hoping this training will further increase my knowledge and help me to engage others in a conversation around this topic.*
- Seeking resources that can help impact what we do with children that may help avoid future addictions due to the ACEs they are currently obtaining
- *I'm trying to promote trauma screening with the pediatricians I train. They are always asking for more information on adolescent addiction.*
- ACEs are always relevant in investigating my client's history. They have usually have numerous ACE factors and have experienced many childhood traumatic events, without appropriate care or support. My clients usually have also have multiple diagnoses and a lengthy history of substance abuse. This webinar was very relevant and helpful for my criminal defense work.
- *I need educational materials on the neuroscience proving ACEs lead to addiction. I'm a sober member of AA for 33 years and only five years ago learned about ACEs. My ACE score is 9. Our organization added a TIR program to address ACEs and launched an ambitious campaign to promote ACEs awareness in all 12-step programs by adding a brochure/pamphlet on ACEs. Can you help us, please to get the proven neuroscience?*
- I am interested in learning more about the biological implications of acute, chronic, and generational trauma as it relates directly to my current educational goal of completing certification in Applied Educational Neuroscience and my professional goals of supporting students and educators through a Social Emotional Learning lens.
- *Addiction as a topic in relationship to ACES is very relevant to human psychology. I want to see how we can work this into an integrative perspective even further and to normalize these behaviors from a trauma/grief-informed, root-cause/whole-person informed lens.*

- So many of the young people we work with are high risk or are already using substances and I would like to better understand the connection between ACEs and how it impacts addiction. I am also the staff training coordinator and this particular training will enhance my ability to support direct care staff learning.
- *Since I have learned about ACEs I have been particularly interested in them due to finding out that I have 8. I am a heroin addict in recovery from addiction and I just celebrated 6 years of sobriety. I am always wanting to expand my knowledge on ACEs for the benefit of myself as well as clients when I do get into practice. I am currently in school at the University of Utah for my BSW and am going for an MSW when I graduate.*
- I am passionate about connecting the dots on aces and addiction and growing resilience in families with trauma histories as well as driving prevention conversations upstream. Motivated from my own trauma recovery work (ACES score of 9) and subsequent struggle to find addiction treatment for my daughter during her pregnancy 2 years ago I organized a community town hall to break stigma on mental health and raise awareness of the growing opioid epidemic. We've since grown into a community prevention coalition where we, with 12 sector partnerships vision to prevent youth substance misuse by growing connections and community. This organization has given me an opportunity to share my passion, experience and hope for the future on a state and local level and I'm interested to learn more so I can continue bridging gaps in trauma informed care to improve connections in family systems. As my daughter continues to do well in her recovery I'm interested now more than ever to find ways to ensure protection for my granddaughter and future generations by bringing the science we have to practice in Tennessee.

#### **Webinar 4: Brooks Keeshin, MD**

- *I work directly with DCFS programs where most children have or are experiencing trauma. Looking to improve my knowledge to apply to my role in psychotropic oversight review and case management for this population.*
- Along with my prior knowledge and experience working with survivors of trauma, I'm in the final few months of my graduate program to become a licensed mental health counselor working with children and adolescence. Since I'm just now beginning my work with a local non-profit and will soon be receiving clients, I thought this was a great opportunity to learn more about how to best support my clients.
- *A significant portion of my practice is dedicated to foster care. Childhood trauma is poorly recognized in the community. As faculty at TTUHSC it is important I be able to best articulate the most evidence based care and resources for this vulnerable population.*
- I provide care coordination for children who enter the Child Welfare System. I provide the initial referral for mental health services in our county. Many of the children are 0-5 and have experienced ongoing trauma. I am interested in increasing my knowledge so I can help educate Child Welfare Social Workers on the need for mental health services for the 0-5 population and the impact of the trauma the children have experienced.
- *I am teaching a trauma informed class for child welfare social workers and am interested in learning more about responses in pediatric settings.*

- I work with children in medical foster care plus I teach medical students and residents and want to know more about how to impact this issue in general pediatric practice.
- My primary SANE role is with the pediatric patient population, however I also care for adolescent and adults, many of whom have childhood trauma experiences. I would like to better understand what is known about the impacts of this on the health of my patients and how to best help them to begin healing.

### **Webinar 5: Megan Gerber, MD, MPH**

- In my current role I am most interested in practical integration of tele-intervention in all aspects of healthcare
- I think it is important to remain aware of how current life events such as COVID 19 interface with past trauma. I found the upcoming training and wanted to attend. I lead our Multi Disciplinary Team and will share information learned there.
- Making meaningful connections with students virtually, especially during COVID. Our students are half and half in the building and virtual.
- I practice online counselling and over 90% of my clients experience or have experienced complex developmental trauma.
- I was informed of this training by a county administrator. I Supervise a person who has had Covid as well as one her the employee's family members. The family member died but my employee is still alive. She returned to work once she was better (after about a month) but when she returned her close relative with whom she lived had died from this virus. I want to find strategies for supporting her as she continues to have direct contact with clients.
- Trauma treatment has transformed since the beginning of the pandemic and utilizing solely telehealth to assist clients. I am always eager to learn more that could assist my clients.
- While I don't directly provide services, I'm usually the first person our clients interact with, so it's important I stay up to date on Victim-Centered strategies, especially as we navigate the added trauma of Covid-19, environmental disasters, and political unrest.

### **Webinar 6: Dr. Leena Singh, Dr. Rachel Gilgoff, Ms. Lacie Ketelhut and Dr. Victoria Sparks**

- There is a need in our state to move beyond the trope often heard in physical health settings: "don't screen for trauma if you don't know what to do about it." I am interested in learning about strategies to move our systems forward, including integrated practice models.
- Wanting more perspective on including ACEs questions during the initial session and broaden my understanding of the 'Domains of Wellness' as interventions. I also want to expand my base of professional support as I continue to support my clients.
- I'm in the field and a lot of people from other departments ask whether they should be screening for ACEs in their departments. While I think it's a good idea to screen for ACEs, I find that providers in other departments don't know what they will do with the information.
- As an ACEs Connection Community Manager I like to learn about bridging the space between finding out about ACEs and guiding them to appropriate resources within their community.

- I have had many ACEs trainings; however, I am very interested in hearing about the next steps after the ACEs are identified. We are based in NY not CA so many of your survey questions do not apply; however, your material should be relevant regardless of state.
- *I work with youth and recognize considerable mental health issues in those who initially come for specific physical complaints. I worked as an MD in a child abuse clinic for 20 years and came to understand effects of violence and trauma suffered early in life. As I am now involved in starting a new endeavor in our area - integrated youth health - I want to continue my education and learning about ACEs and how to help youth move forward.*
- I am a survivor of severe child abuse and its effects. I am currently volunteering and advocating for a trauma responsive society. I am eager to learn all I can about current trauma work/practices. I am especially concerned with what happens after an ACEs screening because I have had to fight for care every step of my journey. I am passionate about making sure that survivors get the care and support they need and deserve.
- *I recently completed a pediatric mental health conference where screening for ACEs was discussed quite a bit. I am very familiar with the ACEs research due to working in child abuse evaluation. I would like to know some ways to integrate results of ACEs questionnaires if we have our older teen patients/families complete this, but I am not certain how to best to do this-hence seeing the title of this webinar drew my attention.*

#### **Webinar 7: Dr. Bart Klika, Dr. Randell Alexander, and Victor Vieth, JD**

- I experienced multiple adverse experiences in childhood and want to be best prepared to help a child that I am advocating for that has also experienced them. I want to help get them onto a path for healing early in life. I didn't get the help I needed until I was an adult.
- *The topic was very interesting to me, as we are currently seeing a lot of families at our clinic that are impacted by violence and the pandemic. The pandemic has impacted them through loss of work or inability to have a safe place to go or to get away from an aggressive person in their home.*
- I am aware of the ACEs study , however would like to understand more the impacts it has on the individual and overall families. Also what we can do as service providers to help in combating this issue to prevent further ACEs from taking place.
- *Though we are not a clinical group, we serve women and children who have experienced severe trauma. To end the cycle of violence, our services need to be aimed at understanding the roots of trauma responses and at healing children who have been exposed to DV or SV.*
- As our work is to prevent and reduce traumatic experiences for children, this webinar touches every piece of our collaborative work from funding priorities, support to districts to direct services for youth.
- *I work with young moms experiencing homelessness. I want to be able to cogently speak with them about their past experiences and how we can try to prevent their children from experiencing the same.*

### **Webinar 8: Bob Sege, MD, PhD**

- *Dr Sege's reputation as a speaker and the inclusion of hope in the title, along with the course description essentially addressing the idea of facilitating joy. I could use that!*
- *I have training in ACEs but am interested in the other side of things, the research on Healthy outcomes as opposed to adverse outcomes. Our center is strength based and our case manager asks each family to identify 3 strong points about their family. I feel we can use this new information when working with families on building their strengths.*
- *Interest in the positive impact of positive life experiences. We are constantly working in trauma and it can feel hopeless to always come from a mindset that trauma trumps all. It would be really interesting from a preventative and treatment lens to learn about protective factors and resilience in this way.*
- *Interest in the link between this work on positive childhood experiences and Hawkins and Catalano's Risk/Protective Factor research from the 80s/90s.*
- *As someone who works on a community/cultural level of adverse experiences, I cannot exclude the individual impact of traumatic experiences on the broader level. This is integral to our culture. Conversely, we must have dialogue of protective factors on a community level. We cannot talk about trauma without also recognizing resiliencies and how to intentionally build them.*
- *We discuss ACEs/PACEs with participants/survivors and internally. It is relevant to my role to stay informed and updated regarding this area of research.*

### **Webinar 9: Dr. Martina Jelley, Dr. Julie Miller-Cribbs, and Dr. Fran Wen**

- *The title meets my need to better teach my team and partners ( community based and institutional) and our medical students and medical residents about Aces*
- *I'm very interested in expanding ACE assessment across our enterprise and, as a teacher in a family medicine residency program, am always looking for new ways to deliver important content to residents. This looks appealing to me.*
- *I teach about the ACES and want to learn as much as I can about it so I can incorporate new knowledge and perceptions in my teaching and practice.*
- *I use the ACEs assessment in my teaching and also used it to complete a study of ACEs in law enforcement and in children in Juvenile Halls in CA. I teach Trauma Informed Care and two other trauma courses and people take the ACEs during the class as well as the resiliency assessment. I want to learn more to improve my teaching and increase my knowledge base.*
- *I would like to know more about ACES because I teach trauma and vicarious trauma classes to our client-facing staff. More information will better inform those staff who work directly with people who have experienced or are currently experiencing violence and trauma.*
- *I am interested in integrating training about the use of ACES with graduate level social work students and as a clinical supervisor. I am also interested in continuing to use simulation as a teaching method for demonstrating and exploring trauma informed care.*

### **Webinar 10: Sharon Cooper, MD**

- *I want to learn all I can to fight against systemic racism and practice and incorporate skills I can use to support my team of providers to do the same for the community that we serve.*
- *Manage staff who do direct patient care and our organization has declared racism is a public health crisis. Would like to give tools to staff to start these conversations.*
- *Advocacy is part of nursing responsibility. Further, I want to do something in my capacity as public health nurse to eliminate discrimination.*
- *A large proportion of my patients and their families identify as BIPOC and families, and I would like to better understand and change their experience in my setting. Learn how to stand up for them and make them feel welcome, heard, and respected."*
- *I am interesting in increasing my own awareness of generational trauma, systemic racism, and discriminatory practices in health care affecting individual, community and cultural health. With what little I have learned, it seems that all of these (individual ACEs, generational trauma, systemic racism and discriminatory practices in health care) likely have significant negative effects on individual, community and cultural health, and becoming more aware of these and of their affects is the first step in moving toward greater health, wellness, wholeness for all. Please note: my responses to questions 1-12 of this part of the survey are within the context of hospital spiritual care visits. Our spiritual care department does not engage in a specific "plan of care" and often I may only visit with a patient one-two times. When patients refer to their childhood experiences and or other traumas, and where chart information may lead me to suspect ACEs, I work to engage ACEs aware spiritual care and as already noted, to consult with providers and nursing staff .*

### **Webinar 11: Bob Sege, MD, PhD and Baraka Floyd, MD**

- *I want to know more about the front end, future-forward thinking in the HOPE model. My job as advocate is to focus on the needs of the family and many times that includes psychoeducation and one-on-one counseling to get them through to the next phase of their investigation.*
- *I run a program to help parents overcome parenting struggles by working on their relationships with each other and themselves to help combat past trauma to better their child's life. I think this is great training for me to better understand ACEs and the community.*
- *The shift on how Positive Childhood Experiences are just as important as Adverse Childhood Experiences.*
- *While I don't directly provide services, I'm usually the first person our clients interact with, so it's important I stay up to date on Victim-Centered strategies, especially as we navigate the added trauma of Covid-19, environmental disasters, and political unrest.*

## CUMULATIVE EVALUATION

A total of 751 individuals completed one or more evaluations, a 19% participation rate. These 751 participants completed a total of 1056 individual evaluations, resulting in an overall response rate of 26%. The geographical and interdisciplinary nature of participants illustrates the breadth needed for building systems and communities which integrate trauma-informed principles. Participants were asked to evaluate how well each event 1) satisfied stated learning objectives, 2) presented evidenced-based material, 3) provided effective presenters, and 4) increased knowledge base. These elements were scored on a 5-point Likert scale from strongly disagree (1), disagree (2), neither agree or disagree (3), agree (4), to strongly agree (5). An analysis of the cumulative rating across all evaluation questions, for all events resulted in a score of 4.7 out of 5; a very positive overall rating.

## EVALUATION OVERVIEW



## CAA & CHANGE

Attendees were asked about the capacity of the events they attended to influence change in their practice behavior with the item: Based upon your participation in this presentation, do you intend to change your practice behavior? Across all events, there were 1,051 indicators of change, indicating what types of changes people planned to make. The top indicated changes reported are ranked below:



### Changes Indicated

Routine screening for ACEs in children	189 (18%)
Routine screening for ACEs in adults	171 (16%)
Applying the ACEs and Toxic Stress Risk Assessment Algorithm to guide patient care	100 (10%)
Change in treatment or management approach, based on ACEs score and toxic stress risk assessment	139 (13%)
Change in current practice for referrals or linkages to treatment and support services	154 (15%)
Change in interprofessional team communication or collaboration, within team in primary clinical setting	135 (13%)
Change in interprofessional communication or collaboration, for referrals and off-site partners	163 (15%)

## Registration & Evaluation: Within Group Comparisons

### COMPLETED EVALUATION

One additional within-group comparison was conducted with the registration and included evaluation considerations. Of those who registered for one or more CAA sessions, 751 (19%) completed an evaluation. Exploring differences between those who did and those who did not complete an evaluation allows us to determine the generalizability of the evaluation responses.

After analyzing the data, no differences were found between the two groups in any area related to demographics or practice settings/activities. This is a good thing. Only 3 of the attitude and practice questions reflected significant differences. These were questions 1, 4, and 11. Again, while statistically different, the responses were very close and reflect no practical difference. Thus, there is every reason to believe that the evaluation responses can be generalized to all CAA registrants.



# EVALUATION OVERVIEW

## REPORTED BARRIERS TO CHANGE

Attendees were also asked what they felt barriers to change might be. The item was:

***Which of the following do you anticipate will be the primary barriers to implementing these changes?***

Respondents were able to select all that they felt applicable. There were a total of 707 responses in regards to perceived barriers and are ranked below.

System constraints	178(25%)
Time constraints	153 (22%)
Patient adherence/compliance	119 (17%)
Treatment-related adverse events	22 (3%)
Insurance/financial issues	54 (8%)
Insufficient interprofessional team support within primary clinical setting	61 (9%)
Ability to refer to appropriate services and treatments	99 (14%)

### Other Barriers to change reported were:

- Doctor participation
- Encouraging families to engage in preventive and "restorative" parenting and maintaining support and understanding of the necessary approaches is an ongoing challenge.
- Encourage practice changes among clinician members
- Covid-19 is limiting my ability to conduct home visits
- Outside agencies do not want to cooperate
- Personal knowledge
- Ability to build teams

## Evaluation by Presenter

**Dr. Vincent J. Felitti**

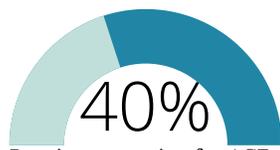
**N=269**

	Strongly Agree-5	Agree-4	Neither Agree or Disagree-3	Disagree-2	Strongly Disagree-1	Mean
The presenter was effective in presenting the material	212(79%)	50(19%)	5(2%)			4.75
The activity enhanced my current knowledge base.	188 (70%)	65 (24%)	11(4%)	3	2	4.61
The educational material provided useful information for my practice.	195 (72%)	56(21%)	16(6%)	2	-	4.64
The content was evidence-based.	223 (83%)	41(15%)	3	2	-	4.80
Define Adverse Childhood Experiences (ACEs), their prevalence, and their impacts on health, including underlying biological mechanisms	219 (81%)	44(16%)	1	1	-	4.78
Identify and inquire about patients' prior traumatic experiences	206 (77%)	56(21%)	6	1	-	4.73
Identify strategies for using a trauma-informed approach to care and integrate this knowledge into patient care	177(66%)	67(25%)	21(8%)	3	1	4.55
Assess and follow-up patient's progress on increasing their resilience	161(60%)	75(28%)	28(10%)	4	1	4.45
Overall Mean						4.66

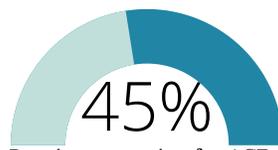
# SPEAKER OUTCOMES

## Dr. Vincent J. Felitti

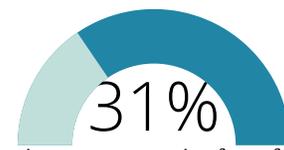
In the evaluation, participants were asked if the webinar had motivated them to change their actions in their respective practice areas. The question asked: “Based upon your participation in this activity, do you intend to change your practice behavior?” Of the 269 evaluations, 192 (71%) indicated they intended to change their practice behavior. Of the 192, 92 (48%) intended to make one change, while the remaining 100 (52%) intended to make changes in multiple areas of their practice. The intended changes are noted below.



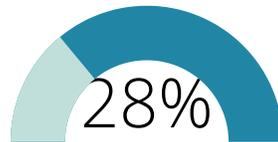
Routine screening for ACEs in adults



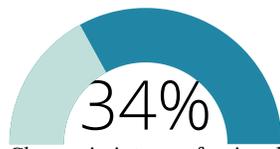
Routine screening for ACEs in children



Change in current practice for referrals or linkages to treatment and support services



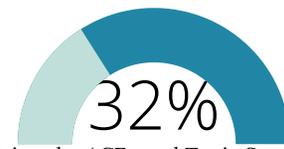
Change in treatment or management approach, based on ACEs score and toxic stress risk assessment.



Change in interprofessional communication or collaboration, for referrals and off-site partners



Change in interprofessional team communication or collaboration, within team in primary clinical setting



Applying the ACEs and Toxic Stress Risk Assessment Algorithm to guide patient care

### Other Changes Indicated

- Provide a handout with ACEs information
- MDs have to agree to allow routine screening for ACEs
- Integrating ACEs in how we are viewing all our cases
- Initial Assessment of CANS
- Information can be shared through public health program
- I am working to implement trauma-informed care now.
- Explaining more about ACEs in reports I write
- Enrich curriculum for MSW students.
- Conduct research
- Being mindful of a person's trauma when I meet with them and discuss their childhood.
- Be more aware of the causes
- Additional communication with clients

## SPEAKER OUTCOMES

### Dr. Vincent J. Felitti

Respondents were asked how confident they felt in making intended changes. Of the 192 who indicated they intended to change their practice behavior, 11 (6%) indicated this question was not applicable. The remaining 181 respondents provided their rating on a 4-point scale: not confident, unsure, somewhat confident and very confident. Of the 181 who indicated they intended to make changes and found the question applicable, 1 (.5%) indicated they were not confident, 27 (15%) were unsure, 66 (36%) were somewhat confident, and 87 (48%) were very confident.

Respondents were asked what they felt their primary barrier to implementing change is. For this item, 180 responses were collected. Barriers listed below:

Barriers	N	%		N	%
Time Constraints	37	20%			
Lack of Interprofessional Support	22	12%	Ability to make appropriate referrals	25	14%
Insurance/Financial Issues	11	6%	Patient Adherence	30	17%
System Constraints	48	27%	Treatment-Related Adverse Events	3	2%

#### Other Barriers Indicated

- Ways to get information about childhood issues with students.
- Perception of irrelevance in my practice area.
- Doctor participation
- Encouraging families to engage in preventive and "restorative" parenting, and maintaining support

#### Bias & Invitation Source

264 of 267 respondents indicated they felt the presentation was free of bias. Of those who indicated bias, the following feedback was provided:

- I would have appreciated more discussion on race and impacts of systemic racism as an ACE
- It focused on one specific demographic (middle class participants)
- This study does not look at adults from other socio-economic back grounds and other race/ethnicities

210 respondents reported how they learned of the event and completed an evaluation. The top sources of invitation were: Colleague email/word of mouth (87 or 41%), Received email from CIR, CAPSAC, APSAC, AVA (46 or 33%), ACES Connection (27 or 13%).

## SPEAKER OUTCOMES

### Dr. Vincent J. Felitti Qualitative Data

*What type of intervention works to help parents and children?*

*This presentation was very informative and will help in my role as an ACEs grantee participant with activities and education to raise awareness with providers in the local health jurisdiction.*

*Thank you!*

*This is hard to dig into as a school nurse without crossing boundaries.*

*The intersection of systemic racism, homophobia, transphobia, xenophobia... on negative outcomes.*

*The information was very good. I would like to receive more information on effective/evidence-based interventions we can use in psychotherapy*

*Thank you for conducting the presentation via zoom and during a workday so that I can attend.*

*More of this! Truly, identifying trauma histories with clients who have not previously disclosed a trauma history and are in a vulnerable position, not seeking treatment. Interviewing skills with people who have a history of complex trauma. Working with family members in a family system approach to learning about trauma history.*

*More about the neurobiology of adversity*

*It seemed very superficial, did not really add anything new - I thought it was going to be more about how to set up practical ways of screening clients*

*I'd like further presentations on how the ACES has been implemented with the Latino and Black populations including any studies done with this population with regards to the ACES. Thank you!*

*I would like to attend a training that discusses appropriate/most effective evidence-based practices to treat clients with high ACE scores and also co-occurring substance use issues.*

*I would have liked to hear more about the details of the study questions. Also, address the question of association vs causality. Very interested in what has been published on resilience and evidence-based screening/interventions for ACES.*

*I work with teen mothers in the central valley and I would be interested in learning more about how to support individuals with multiple different types of trauma.*

*I work with survivors of domestic violence and am interested in the cycles of violence whereby those who witness or experience childhood abuse or DV will later either perpetrate or continuously be in relationships that replicate their trauma.*

*I continue to learn about ACES and how to use it in my role when assessing clients.*

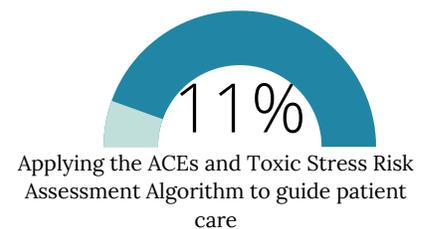
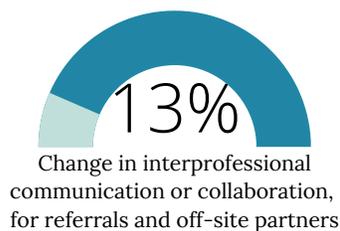
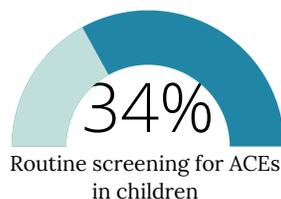
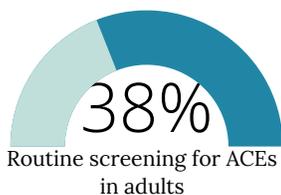
## Evaluation by Presenter

Dr. R.J. Gillespie N=164	Strongly Agree-5	Agree-4	Neither Agree or Disagree 3	Disagree-2	Strongly Disagree-1	Mean
The presenter was effective in presenting the material	134 (82%)	26 (16%)	1	-	3	4.76
The activity enhanced my current knowledge base.	117 (71%)	43 (26%)	2	-	2	4.66
The educational material provided useful information for my practice.	113 (70%)	39 (24%)	9 (5%)	1	2	4.59
The content was evidence-based.	121 (78%)	35 (21%)	6 (4%)	-	1	4.66
Describe AAP's recommendations for Medical Home's response to toxic stress	91 (55%)	61 (37%)	9 (5%)	2	1	4.46
Discuss integration of parental ACE assessments into clinical care	117 (71%)	40 (24%)	4 (2%)	1	1	4.66
Identify ways that primary care / community-based organizations / mental health partnerships may be able to repair patients and families	42 (26%)	29 (18%)	3	1	-	4.53
Overall Mean						4.60

# SPEAKER OUTCOMES

## Dr. R.J. Gillespie

In the evaluation, participants were asked if the webinar had motivated them to change their actions in their respective practice areas. The question asked: “Based upon your participation in this activity, do you intend to change your practice behavior?” Of the 164 evaluations, 112 (68%) indicated they intended to change their practice behavior. Of the 112, 49 (44%) intended to make one change, while the remaining 63 (56%) intended to make changes in multiple areas of their practice. The intended changes are noted below.



### Other Changes Indicated

- Paying closer attention to the parents
- Discuss when and how to start screening parents

## SPEAKER OUTCOMES

### Dr. R.J. Gillespie

Respondents were asked how confident they felt in making intended changes.

Respondents provided their rating on a 4-point scale: not confident, unsure, somewhat confident and very confident. Of the 112 who indicated they intended to make changes, 1 (.8%) indicated they were not confident, 7 (6%) were unsure, 59 (53%) were somewhat confident, and 45 (40%) were very confident.

Respondents were asked what they felt their primary barrier to implementing changes is. For this item, 137 responses were collected. Barriers listed below:

Barriers	N	%		N	%
Time Constraints	36	21%			
Lack of Interprofessional Support	14	10%	Ability to make appropriate referrals	18	13%
Insurance/Financial Issues	9	7%	Patient Adherence	24	18%
System Constraints	31	23%	Treatment-Related Adverse Events	2	1%

#### Other Barriers Indicated

- Leadership, system, interprofessional support
- Lack of services
- Encourage practice changes among clinician members

#### Bias & Invitation Source

- There were 93 responses for the item measuring if attendees felt the presentation was free of bias. Of those 93, 100% agreed it was free of bias.
- 56 respondents reported how they learned of the event and completed an evaluation. The top sources of invitation were: Colleague email/word of mouth (14 or 25%), Received email from CIR, CAPSAC, APSAC, AVA (26 or 46%), ACES Connection (16 or 29%).

## SPEAKER OUTCOMES

### Dr. R.J. Gillespie Qualitative Data

*Very informative!*

*Using ACES as a tool of supervision*

*Treatment curriculum for addressing ACES in Adults to be delivered by mental health clinicians.*

*Training and implementation of TIC broadly in the primary care setting for all staff. Also TIC in the ER setting.*

*This was a very well-thought-out and thorough presentation packed with concise information. The time frame worked out perfectly! Like a lunch and learn session.*

*The Webinar was very informative. A lot of information. This webinar could be offered for at least 3 hours.*

*Thank you! I hope to attend other Training sessions to learn as much as I can to share and empower my families to seek support.*

*More on ACES. Thanks for the work you do--*

*More material on specifics on how ACEs are implemented in practice--e.g., how ACE questionnaire is administered to clients/patients, how staff is trained in asking questions and engaging clients/pts in a trauma-informed manner, etc.*

*Limitations of ACES training in our BH services and the limitations to receive training in our agency.*

*In Montana. I am confident this method would work in a CAC here in Montana. Future endeavors*

*Immigration and toxic stress related to ACEs*

*I would like the details on the resilience promoting interactions that Dr. Gillespie alluded to*

*I would have appreciated, having spoken with co-workers, a small review of ACEs in the beginning-- would have been extremely valuable.*

*I work with adults in a justice setting so was probably not the primary target audience, however, I still found this training very informative and relevant to my work. Thank you for providing it.*

*I have felt validated for my beliefs and interactions with the parents I worked with during my career.*

*Here for Learning purposes only and I truly appreciate it all. Thank you.*

*Extremely informative and beneficial for those working with youth of all ages.*

*Dr. Gillespie did not respond to my question as to how to integrate the program into a designated 10–15-minute office visit that also includes general questions about child's health, physical examination, vaccinations, and advice,*

*Continuing education on ACEs and the effects on CNS and bodily organs*

*Continuing education on ACEs*

*Accessibility of training to all hospital units- would be informative in meetings for appropriate patient care*

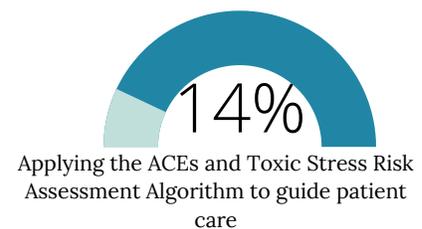
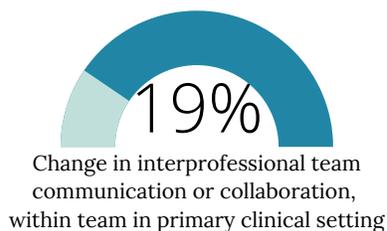
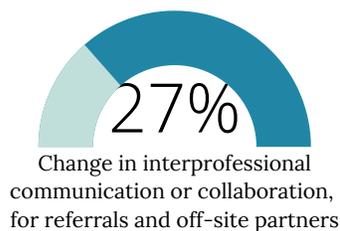
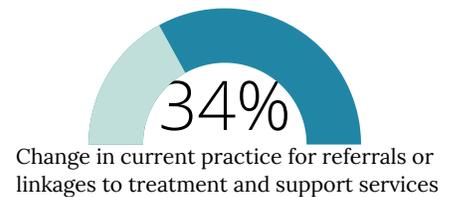
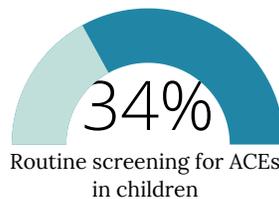
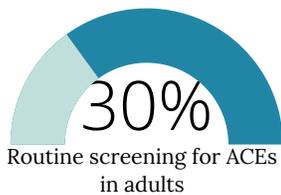
## Evaluation by Presenter

Dr. Susie Wiet N=129	Strongly Agree-5	Agree-4	Neither Agree or Disagree-3	Disagree-2	Strongly Disagree-1	Mean
The presenter was effective in presenting the material	92 (80%)	22 (19%)	1	-	-	4.83
The activity enhanced my current knowledge base.	88 (77%)	23 (20%)	4	-	-	4.77
The educational material provided useful information for my practice.	77 (67%)	31 (27%)	7 (6%)	-	-	4.62
The content was evidence-based.	81 (70%)	28 (24%)	5 (4%)	1	-	4.83
Discuss the basics of the neurobiology of the stress management pathway	82 (71%)	31 (27%)	2	-	-	4.77
Explain the interface of the reward pathway with stress	79 (69%)	33 (29%)	2	1	-	4.74
Describe the imbalances of the stress and reward pathways that lead to addictions	82 (71%)	29 (25%)	3	1	-	4.74
Utilize the interventions that assist with restoration of the neurobiology of balance (homeostasis)	68 (59%)	37 (32%)	8 (7%)	2	-	4.54
Overall Mean						4.75

# SPEAKER OUTCOMES

## Dr. Susie Wiet

In the evaluation, participants were asked if the webinar had motivated them to change their actions in their respective practice areas. The question asked: “Based upon your participation in this activity, do you intend to change your practice behavior?” Of the 129 evaluations, 62 (48%) indicated they intended to change their practice behavior. Of the 62, 32 (52%) intended to make one change, while the remaining 30 (48%) intended to make changes in multiple areas of their practice. The intended changes are noted below.



### Other Changes Indicated

- I work in the legal field; I will use the information to enhance and inform my understanding interviews
- Prevention presentations
- Since I am a capital mitigation specialist I will use the information to assist looking for an expert.
- The content of what I teach UG and GR students
- Use some of the methods outlined for homeostasis
- Working with those that support families and children to engage the knowledge presented

# SPEAKER OUTCOMES

## Dr. Susie Wiet

Respondents were asked how confident they felt in making intended changes.

Respondents provided their rating on a 4-point scale: not confident, unsure, somewhat confident and very confident. Of the 62 who indicated they intended to make changes, 1 (2%) indicated they were not confident, 5 (8%) were unsure, 31 (50%) were somewhat confident, and 24 (39%) were very confident.

Respondents were asked what they felt was their primary barrier(s) to implementing changes. For this item, 101 responses were collected. Barriers listed below:

Barriers	N	%		N	%
Time Constraints	20	20%			
Lack of Interprofessional Support	7	7%	Ability to make appropriate referrals	15	15%
Insurance/Financial Issues	15	15%	Patient Adherence	21	21%
System Constraints	15	15%	Treatment-Related Adverse Events	3	3%

### Other Barriers Indicated

- COVID restrictions
- I need more information on clinical algorithm on ACEs and toxic stress. This was not clear for me.
- Teaching/training Per Diem staff to view addiction from a different lens instead of the conventional view
- Transportation and available resources at this time.
- My personal lack of knowledge

### Bias & Invitation Source

- 100% of the 111 respondents indicated they felt the presentation was free of bias
- 113 respondents reported how they learned of the event and completed an evaluation. The top sources of invitation were: Colleague email/word of mouth (34 or 30%), Received email from CIR, CAPSAC, APSAC, AVA (49 or 43%), ACES Connection (30 or 26%).

## SPEAKER OUTCOMES

### Dr. Susie Wiet Qualitative Data

*We see a lot of developmental trauma so maybe more about trauma in utero and within the first two years of life and how it impacts development. Also, how substance abuse in utero can affect the child.*

*Use of psychotropic medications.*

*Treatment modalities*

*This was really great, and I have been thinking about it a lot since the presentation. I would have benefited from a little more plain-language explanations. I am a mental health professional but not a doctor. I really appreciate this training thank you!*

*The healing potential of creativity.w Working with children with severe neglect and abuse Dissociative disorders' treatment*

*Thank you!!*

*Thank you for this exceptional work!*

*More on resilience and what strategies to help school-age children with developing resilience.*

*It was very technical and heady. I would have liked for a translation to more common parlance.*

*Immigration and toxic stress*

*I found the sessions interesting but a LOT of information.*

*Great job presenting a complex subject.*

*Application of this session to patients with FASD - remedial address in older adolescents and adults.*

## Evaluation by Presenter

**Dr. Brooks Keeshin**

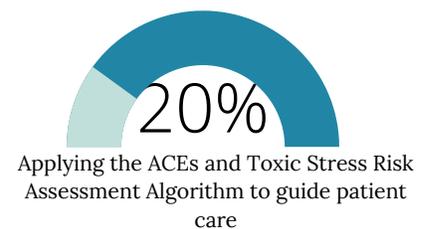
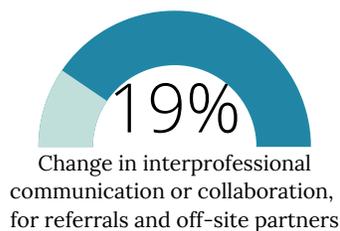
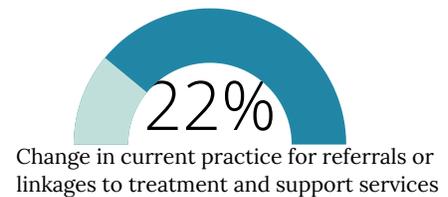
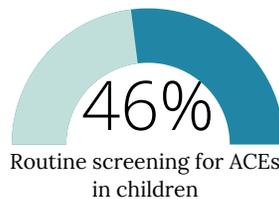
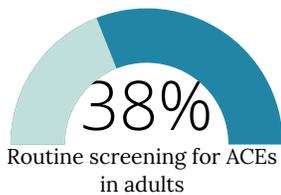
**N=95**

	Strongly Agree-5	Agree-4	Neither Agree or Disagree-3	Disagree-2	Strongly Disagree-1	Mean
The presenter was effective in presenting the material	83 (87%)	12 (13%)	-	-	-	4.87
The activity enhanced my current knowledge base.	75 (79%)	16 (17%)	1	1	-	4.77
The educational material provided useful information for my practice.	69 (73%)	20 (21%)	-	-	-	4.70
The content was evidence-based.	87 (92%)	6 (6%)	-	-	-	4.94
Identify and respond to pediatric traumatic stress	78 (82%)	13 (14%)	1	1	-	4.81
Describe the Care Process Model (CPM) for Pediatric Traumatic Stress	76 (80%)	16 (17%)	1	-	-	4.81
Discuss pilot implementation and findings	78 (82%)	13 (14%)	1	1	-	4.81
Overall Mean						4.80

# SPEAKER OUTCOMES

## Dr. Brooks Keeshin

In the evaluation, participants were asked if the webinar had motivated them to change their actions in their respective practice areas. The question asked: “Based upon your participation in this activity, do you intend to change your practice behavior?” Of the 95 evaluations, 56 (59%) indicated they intended to change their practice behavior. Of the 56, 20 (36%) intended to make one change, while the remaining 36 (64%) intended to make changes in multiple areas of their practice. The intended changes are noted below.



### Other Changes Indicated

- Try to convince medical doctors to incorporate screening
- Promote trauma-informed contacts with medical and legal services
- CPM screener
- Additional discussion within the practice regarding changes

## SPEAKER OUTCOMES

### Dr. Brooks Keeshin

Respondents were asked how confident they felt in making intended changes.

Respondents provided their rating on a 4-point scale: not confident, unsure, somewhat confident and very confident. Of the 56 who indicated they intended to make changes, 0 indicated they were not confident, 4 (7%) were unsure, 35 (63%) were somewhat confident, and 17 (30%) were very confident.

Respondents were asked what they felt their primary barrier to implementing changes is. For this item, there were 58 responses.

Barriers listed below:

Barriers	N	%		N	%
Time Constraints	13	22%			
Lack of Interprofessional Support	4	7%	Ability to make appropriate referrals	11	19%
Insurance/Financial Issues	3	5%	Patient Adherence	10	17%
System Constraints	13	22%	Treatment-Related Adverse Events	2	3%

### Other Barriers Indicated

- Lack of resources in the area
- Identifying the best way to utilize for training. Intend to pass on to several clinicians that I know.

### Bias & Invitation Source

- There were 93 responses for the item measuring if attendees felt the presentation was free of bias. Of those, 100% agreed it was free of bias.
- 91 respondents reported how they learned of the event and completed an evaluation. The top sources of invitation were: Colleague email/word of mouth (28 or 31%), Received email from CIR, CAPSAC, APSAC, AVA (52 or 57%), ACES Connection (11 or 12%).

## SPEAKER OUTCOMES

### Dr. Brooks Keeshin Qualitative Data

*You all did a really good job on this presentation! I cannot wait to attend another one.*

*Updated EBP research for reflexology / massage therapy/ music/art therapy to benefit clients (ages 8-up).*

*Thank you, I found the information valuable.*

*I would love for more presentations to specifically address children within the child welfare system and complex trauma in general.*

*I would like to have more screen time with each of the presented pages. It would help to have one page of email/website contacts to be able to take a screenshot as a reference.*

*I work in an inpatient unit and would be interested in how to incorporate this into a more intensive/critical care environment.*

*How to utilize the different psychotherapy approaches in children with traumatic experiences.*

*How to support infant mental health and families who have experienced trauma*

*How can we coordinate with schools, especially elementary schools where the common belief is that a disruptive child has ADHD? A lot of clinicians seem to think the same thing. We had a kindergartner who discovered his dead father, had a mother who did not want him and turned him over to Grandma, and the clinician prescribed ADHD medication which made him violent.*

*Excellent presentation as a clinical professional working for an accreditation body to ensure that our standards reflect current best practice*

*Excellent presentation--includes the impressive wealth of knowledge that was apparent in Brooks. He spoke nice and slow, too! Appreciate the efforts and the sharing of the data, forms, processes, etc...Will allow for adjunct P&P in order to ensure the best outcomes for our members. Thank you!*

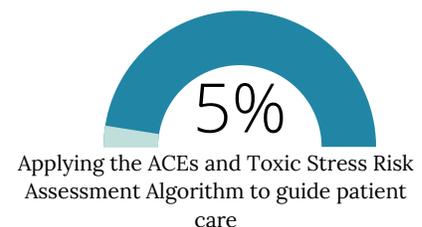
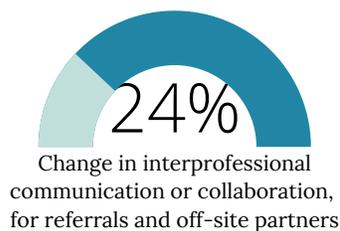
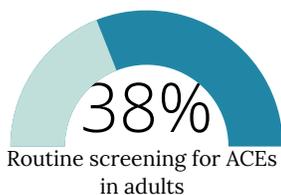
## Evaluation by Presenter

Dr. Megan Gerber N=84	Strongly Agree-5	Agree-4	Neither Agree or Disagree-3	Disagree-2	Strongly Disagree-1	Mean
The presenter was effective in presenting the material	61 (73%)	21 (27%)	2	-	-	4.83
The activity enhanced my current knowledge base.	59 (70%)	22 (26%)	2	2	-	4.65
The educational material provided useful information for my practice.	54 (64%)	22 (26%)	7 (8%)	1	-	4.53
The content was evidence-based.	61 (73%)	19 (23%)	4	-	-	4.78
Recognize the adverse, long-term health impact that adverse childhood experiences (ACEs) and other traumas have on primary care patients.	70 (83%)	11 (13%)	2	-	-	4.85
Identify how the COVID-19 pandemic and other recent events (such as police killings and wildfires) may be worsening outcomes for trauma-exposed children and adults.	65 (77%)	16 (19%)	2	-	-	4.83
Develop ways to apply principles of trauma-informed care during these challenging times.	56 (66%)	23 (27%)	3	1	-	4.68
Overall Mean						4.68

# SPEAKER OUTCOMES

## Dr. Megan Gerber

In the evaluation, participants were asked if the webinar had motivated them to change their actions in their respective practice areas. The question asked: “Based upon your participation in this activity, do you intend to change your practice behavior?” Of the 82 evaluations, 59 (72%) indicated they intended to change their practice behavior. Of the 59, 30 (51%) intended to make one change, while the remaining 29 (49%) intended to make changes in multiple areas of their practice. The intended changes are noted below.



### Other Changes Indicated

- More staff training in trauma informed approaches
- Little things make a big difference. Narrate more, make sure lighting is good in a session, because
- I will enhance the trauma-informed approach to my telehealth visits
- Encourage providers I work with to implement trauma-informed telehealth practices

# SPEAKER OUTCOMES

## Dr. Megan Gerber

Respondents were asked how confident they felt in making intended changes.

Respondents provided their rating on a 4-point scale: not confident, unsure, somewhat confident and very confident. Of the 59 who indicated they intended to make changes, 0 indicated they were not confident, 2 (3%) were unsure, 31 (53%) were somewhat confident, and 26 (44%) were very confident.

Respondents were asked what they felt their primary barrier to implementing changes is. For this item, 57 responses were collected. Barriers listed below:

Barriers	N	%		N	%
Time Constraints	16	28%			
Lack of Interprofessional Support	1	2%	Ability to make appropriate referrals	7	12%
Insurance/Financial Issues	1	2%	Patient Adherence	9	16%
System Constraints	16	28%	Treatment-Related Adverse Events	5	8%

### Other Barriers Indicated

- Job location
- Covid-19 is limiting my ability to conduct home visits

### Bias & Invitation Source

- 100% of the 82 respondents indicated they felt the presentation was free of bias.
- 71 respondents reported how they learned of the event and completed an evaluation. The top sources of invitation were: Colleague email/word of mouth (28 or 39%), Received email from CIR, CAPSAC, APSAC, AVA (32 or 45%), ACES Connection (11 or 15%).

## SPEAKER OUTCOMES

### Dr. Megan Gerber Qualitative Data

*Well done as always*

*This presentation was very high quality and thought-provoking. Dr. Gerber was able to cover a significant amount of content in a relatively short amount of time. I would love to see Dr. Gerber back for Part Two!*

*This presentation has been really useful, insightful, and practical. Thanks, folks for making this available. World Class.*

*Thank you for opening this presentation to different agencies. I will appreciate having access to printouts.*

*The presentation was excellent, need to start using ACES, just now learning about it.*

*More treatment approaches for mental health providers using ACES in the treatment of adults.*

*I am an MFT and I thoroughly enjoyed this presentation. I liked the speaker and she had a great flow and energy throughout the presentation. I hope to take more CEU's in the near future.*

*I am a CASA volunteer and the information has helped me work with the parents of the children I advocate for. It would help to have a question about working with clients when not working in a therapeutic setting.*

*Great training, it's helpful to continue to learn about the current/ongoing impact of current stressors we are all facing at this time.*

*Excellent presentation!! Truly helped my understanding of trauma-informed care and the transition to Telehealth! Thank you very much!!*

*Engaging staff in TIC - especially those with trauma history themselves*

*All of this presentation makes perfect sense!*

Dr. Leena Singh, Dr. Rachel Gilgoff, Ms.Lacie Ketelhut, and Dr. Victoria Sparks N=60

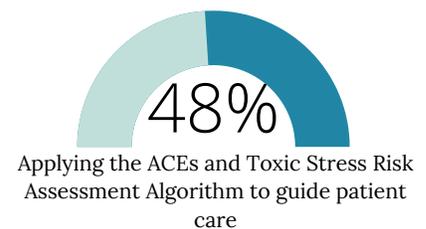
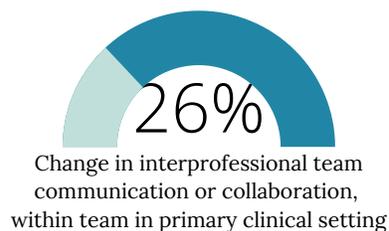
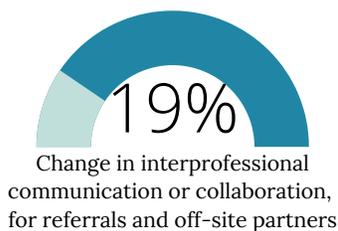
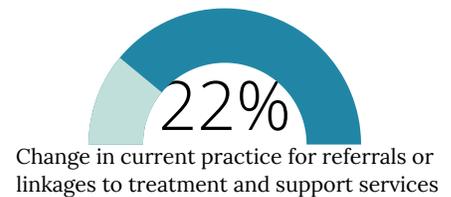
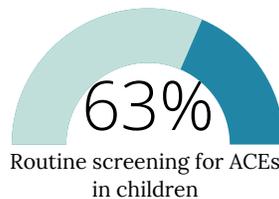
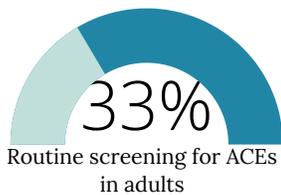
Evaluation by Presenter

	Strongly Agree-5	Agree-4	Neither Agree or Disagree 3	Disagree-2	Strongly Disagree-1	Mean
The presenter was effective in presenting the material	45 (75%)	14 (23%)	-	-	1	4.68
The activity enhanced my current knowledge base.	40 (67%)	18 (30%)	1	-	1	4.57
The educational material provided useful information for my practice.	42 (70%)	15 (25%)	2	-	1	4.62
The content was evidence-based.	38 (63%)	20(33%)	1	-	1	4.62
Describe methods for assessing protective factors and symptoms related to childhood adversity	40 (67%)	16 (27%)	2	2	-	4.49
Discuss the domains of wellness (sleep, relationships, nutrition, physical activity, nature, mindfulness, and mental health) with patients as interventions for symptoms related to adversity	44 (73%)	14 (23%)	1	-	1	4.63
Identify opportunities for expanding ACE screening and response in the pediatric setting	40 (67%)	17 (28%)	2	-	1	4.60
Review key considerations for successful ACEs screening implementation and response	42 (68%)	15 (28%)	2	-	1	4.60
Describe the benefits of a relationship-based community change model to encourage collaborative work across community partners	43 (70%)	16(27%)	-	-	1	4.71
Outline a framework for mobilizing community partnerships to effectively respond to impact of ACEs through aligned actions	38 (63%)	17 (28%)	3	1	1	4.51
					Overall Mean	4.61

# SPEAKER OUTCOMES

## Dr. Leena Singh, Dr. Rachel Gilgoff, Ms. Lacie Ketelhut, and Dr. Victoria Sparks

In the evaluation, participants were asked if the webinar had motivated them to change their actions in their respective practice areas. The question asked: “Based upon your participation in this activity, do you intend to change your practice behavior?” Of the 60 evaluations, 21 (35%) indicated they intended to change their practice behavior. Of the 21, 11 (52%) intended to make one change, while the remaining 10 (48%) intended to make changes in multiple areas of their practice. The intended changes are noted below.



### Other Changes Indicated

- Standards modification
- Teaching more about the model to students
- Research
- Continue discussions of screening for ACEs in primary care and mental health clinic

## SPEAKER OUTCOMES

### Dr. Leena Singh, Dr. Rachel Gilgoff, Ms. Lacie Ketelhut, and Dr. Victoria Sparks

Respondents were asked how confident they felt in making intended changes. Respondents provided their rating on a 4-point scale: not confident, unsure, somewhat confident and very confident. Of the 21 who indicated they intended to make changes, 0 indicated they were not confident, 2 (10%) were unsure, 11 (52%) were somewhat confident, and 8 (38%) were very confident.

Respondents were asked what they felt their primary barrier to implementing changes is. For this item, there were 34 responses. Barriers listed below:

Barriers	N	%		N	%
Time Constraints	6	18%			
Lack of Interprofessional Support	4	12%	Ability to make appropriate referrals	3	9%
Insurance/Financial Issues	5	15%	Patient Adherence	6	18%
System Constraints	10	29%	Treatment-Related Adverse Events	-	-

### Other Barriers Indicated

- Outside agencies do not want to cooperate

### Bias & Invitation Source

- There were 50 responses for the item measuring if attendees felt the presentation was free of bias. All 50 agreed it was free of bias.
- 50 respondents reported how they learned of the event and completed an evaluation. The top sources of invitation were: Colleague email/word of mouth (10 or 20%), Received email from CIR, CAPSAC, APSAC, AVA (30 or 60%), ACES Connection (10 or 20%).

### Qualitative Data

*Very well done! Thank you for a great presentation!*

*These series are great!*

*The description of this webinar was not congruent with some of the material. Knowing what the community approach for one region looked like was helpful, but the presenter could not talk in detail about protocol or response, which is what helps develop other communities.*

*I would like information on becoming certified*

*I joined the webinar to inform my team who recently received an AA grant.*

Dr. Bart Klika, Dr. Randell  
Alexander, and Victor Vieth,JD  
N=94

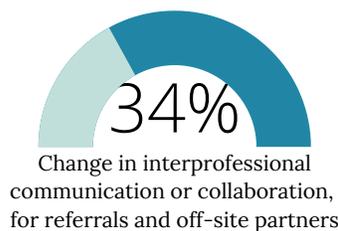
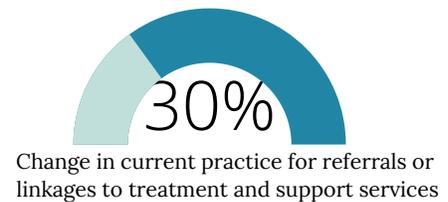
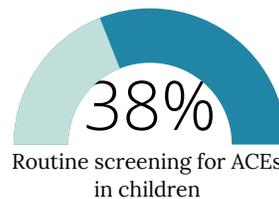
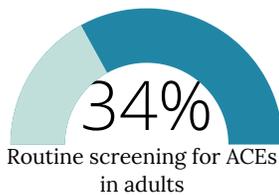
Evaluation by Presenter

	Strongly Agree-5	Agree-4	Neither Agree or Disagree-3	Disagree-2	Strongly Disagree-1	Mean
The presenter was effective in presenting the material	72 (77%)	22 (23%)	-	-	-	4.73
The activity enhanced my current knowledge base.	56(60%)	33 (35%)	5 (5%)	-	-	4.54
The educational material provided useful information for my practice.	62 (66%)	26 (28%)	5 (5%)	-	1	4.57
The content was evidence-based.	72 (77%)	22 (23%)	-	-	-	4.77
List at least 3 countries that have banned corporal punishment.	59 (63%)	28 (30%)	7 (7%)	-	-	4.55
Describe some of the adverse effects of hitting on the brain	71 (76%)	23 (24%)	-	-	-	4.76
Describe some of the adverse long term health effects of hitting	70 (4%)	21 (22%)	3	-	-	4.71
List some of the components of a No Hit Zone	68 (72%)	25 (27%)	1	-	-	4.71
Summarize the literature on the impact of ACEs on health and wellbeing	64 (68%)	27 (30%)	3	-	-	4.65
Describe a comprehensive public health approach to preventing ACEs	58 (60%)	29 (30%)	6	2	-	4.53
Discuss the evidence for policy-level strategies for prevention of ACEs	58 (62%)	28 (30%)	8	-	-	4.53
Recognize the impact of abuse on spirituality	70 (74%)	23 (24%)	1	-	-	4.73
Discuss the role of spirituality in coping with abuse	56 (60%)	27 (29%)	10 (11%)	1	-	4.69
Identify concrete steps for coordinating medical, mental health, and spiritual care resources for a victim of child abuse	56 (60%)	27 (30%)	10 (11%)	1	-	4.47
					Overall Mean	4.64

# SPEAKER OUTCOMES

## Dr. Bart Klika, Dr. Randell Alexander, and Victor Vieth, JD

In the evaluation, participants were asked if the webinar had motivated them to change their actions in their respective practice areas. The question asked: “Based upon your participation in this activity, do you intend to change your practice behavior?” Of the 94 evaluations, 46 (49%) indicated they intended to change their practice behavior. Of the 46, 26 (57%) intended to make one change, while the remaining 20 (43%) intended to make changes in multiple areas of their practice. The intended changes are noted below.



### Other Changes Indicated

- Adopt the No hitting zone
- Watch for symptoms in students and help educate parents
- Use this information to educate parents and providing appropriate referrals based off this information
- I would like to make my hospital a No Hit Zone
- Be more aware of spirituality in identifying and treating ACEs
- If I was practicing I would definitely work on routine screening and work with community providers esp the spirituality

## SPEAKER OUTCOMES

### Dr. Bart Klika, Dr. Randell Alexander, and Victor Vieth,JD

Respondents were asked how confident they felt in making intended changes.

Respondents provided their rating on a 4-point scale: not confident, unsure, somewhat confident and very confident. Of the 46 who indicated they intended to make changes, 0 indicated they were not confident, 3 (6%) were unsure, 17 (37%) were somewhat confident, and 26 (57%) were very confident.

Respondents were asked what they felt their primary barrier to implementing changes is. For this item, there were 37 responses. Barriers listed below:

Barriers	N	%		N	%
Time Constraints	9	20%			
Lack of Interprofessional Support	1	2%	Ability to make appropriate referrals	5	11%
Insurance/Financial Issues	-	-	Patient Adherence	8	17%
System Constraints	12	26%	Treatment-Related Adverse Events	2	4%

#### Other Barriers Indicated

- HIPPA misinterpretation

#### Bias & Invitation Source

- There were 93 responses for the item measuring if attendees felt the presentation was free of bias. Of those, 92 agreed it was free of bias. The person who did not feel the presentation was free of bias stated, "Felt dr. did too much talking and not enough listening."
- 94 respondents reported how they learned of the event and completed an evaluation. The top sources of invitation were: Colleague email/word of mouth (27 or 20%), Received email from CIR, CAPSAC, APSAC, AVA (49 or 60%), ACES Connection (18 or 20%).

## SPEAKER OUTCOMES

### Dr. Bart Klika, Dr. Randell Alexander, and Victor Vieth, JD Qualitative Data

*Well-rounded presentation and new information which I shared with some counseling friends*

*The presentation was outstanding. I do wish it could be longer. Perhaps 2 hours!*

*The impact of ACE's and toxic stress on pregnancy (I asked a question during the webinar, but it was not answered)*

*Providing results of ACEs to parents within the practice*

*Thanks for an amazing presentation!*

*More evidence-based information on specifics of coordinating of services. How long are they needed (services for a crisis) and how effective are crisis interventions for children? How do you measure children's resilience?*

*Incorporating an examination of ACES science and/or trauma-informed care within multiple medical domains (e.g., neurology/neurological disorders)*

*I thought the presentations were great. Each presenter was extremely knowledgeable and I enjoyed the webinar.*

*I really appreciated how the presenters kept to their time limit, which enabled us to have lots of question/answer time in the end! I haven't been to many webinars that allowed as much time for Q&A at the end as this one did, it was great!*

*I believe this was a good presentation but there was no mention of historical trauma in relation to spanking and/or the cultural implications. I think it is very important when talking about parent education around spanking/hitting to also acknowledge the cultural/historical perspective and how to address these issues based on this.*

*I am grateful for this extremely helpful and high-level presentation. The speakers were excellent and it was well worth my time.*

*Evidence-based ways of coordinating the needed crisis type of services. Impact of the services and length of time needed to be effective.*

*Any additional info on ACEs and their impact on health. The spirituality section was especially helpful to me.*

*Thank you for the presentation*

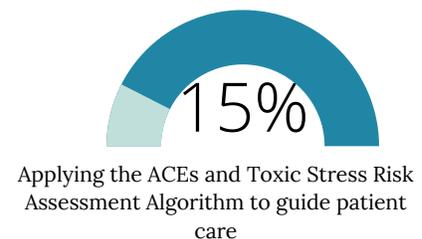
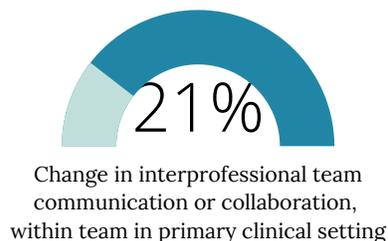
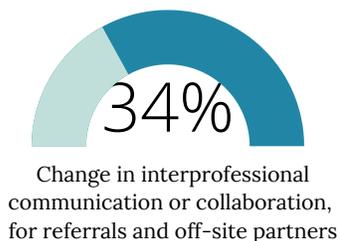
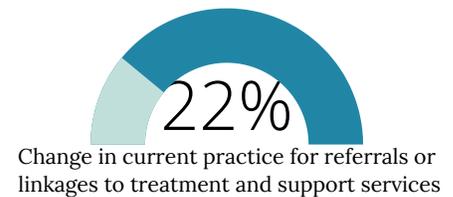
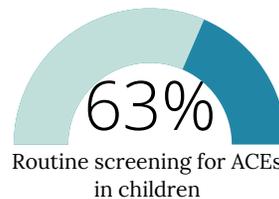
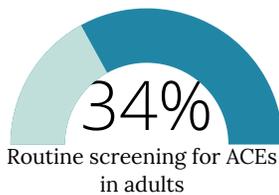
## Evaluation by Presenter

Dr. Robert Sege N=71	Strongly Agree-5	Agree-4	Neither Agree or Disagree-3	Disagree-2	Strongly Disagree-1	Mean
The presenter was effective in presenting the material	72 (77%)	22 (23%)	-	-	-	4.79
The activity enhanced my current knowledge base.	50 (60%)	19 (35%)	2(5%)	-	-	4.68
The educational material provided useful information for my practice.	53 (66%)	18 (28%)	-	-	-	4.75
The content was evidence-based.	56 (77%)	15 (23%)	-	-	-	4.79
Describe the relationship between childhood and adult outcomes	56 (63%)	15 (30%)	-	-	-	4.79
List at least 3 of 7 kinds of positive childhood experiences that are associated with protecting adult mental health in a population	54 (76%)	17 (24%)	-	-	-	4.76
Describe some of the adverse long term health effects of hitting	50 (74%)	18 (22%)	3	-	-	4.66
Overall Mean						4.74

# SPEAKER OUTCOMES

## Dr. Robert Sege

In the evaluation, participants were asked if the webinar had motivated them to change their actions in their respective practice areas. The question asked: “Based upon your participation in this activity, do you intend to change your practice behavior?” Of the 71 evaluations, 40 (56%) indicated they intended to change their practice behavior. Of the 40, 23 (57.5%) intended to make one change, while the remaining 17 (42.5%) intended to make changes in multiple areas of their practice. The intended changes are noted below.



### Other Changes Indicated

- Working with other community partners in offering resources
- Practices to mitigate ACEs and promote PCEs
- Talk about positive experiences and ask about those in families
- Screening for PCE's
- Offer positive parenting suggestions to reinforce positive childhood experiences
- Incorporate HOPE in trainings
- Include PCE in research design
- How I discuss ACEs with families
- CASA work, identifying ACEs and looking for positive
- Attention to positives that promote hope
- Adding information to teaching materials

## SPEAKER OUTCOMES

### Dr. Robert Sege

Respondents were asked how confident they felt in making intended changes. Respondents provided their rating on a 4-point scale: not confident, unsure, somewhat confident and very confident. Of the 40 who indicated they intended to make changes, 0 indicated they were not confident, 3 (8%) were unsure, 9 (23%) were somewhat confident, and 28 (70%) were very confident. Of the 71 evaluations, 24 (33%) indicated this item was not applicable.

Respondents were asked what they felt their primary barrier to implementing changes is. For this item, there were 27 responses. Barriers listed below:

Barriers	N	%		N	%
Time Constraints	4	10%			
Lack of Interprofessional Support	1	2%	Ability to make appropriate referrals	4	10%
Insurance/Financial Issues	2	5%	Patient Adherence	6	30%
System Constraints	8	20%	Treatment-Related Adverse Events	-	-

### Other Barriers Indicated

- Retraining what and how I see
- Remembering

### Bias & Invitation Source

- There were 67 responses for the item measuring if attendees felt the presentation was free of bias. Of those, 66 (98.5%) agreed it was free of bias. The one person who felt the presentation was not free of bias stated, "the discussion related to racism was discriminatory towards some groups."
- 76 respondents reported how they learned of the event and completed an evaluation. The top sources of invitation were: Colleague email/word of mouth (18 or 24%), Received email from CIR, CAPSAC, APSAC, AVA (42 or 55%), ACES Connection (16 or 21%).

### Qualitative Data

*The presentation was very helpful ! It augments previous training I received on brain research and ACEs. Thank you for including non-medical participants like myself. I will look for positive experiences that help build resilience for my CASA kids.*

*Though my practice is currently centered on older adults experiencing chronic illness, I have found the information and education gained from these sessions supportive of my practice at a deep level. I have been very happy with these sessions and the ways my participation has translated to expansion in my practice.*

*Just one comment that I found the beginning of the presentation moved very quickly- including slides and the slides were not super clear (especially graphics) via the zoom platform. Sometimes I wanted more time to take in what had been said/shown before moving to the next slide. Otherwise, it was one of the best webinars I've participated in in the last year.*

**Dr. Martina Jelley, Dr. Julie Miller-Cribbs, and Dr. Fran Wen N=50**

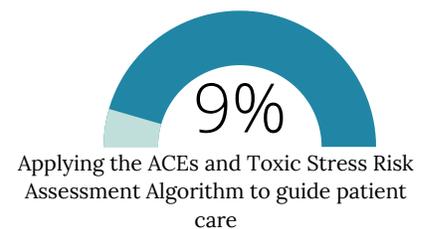
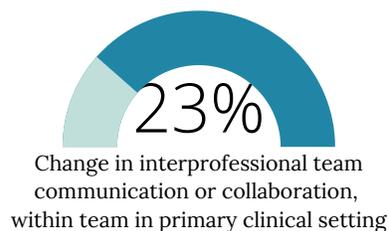
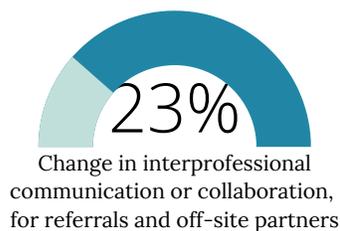
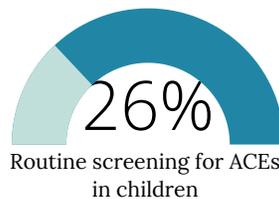
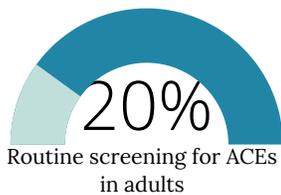
**Evaluation by Presenter**

	Strongly Agree-5	Agree-4	Neither Agree or Disagree-3	Disagree-2	Strongly Disagree-1	Mean
The presenter was effective in presenting the material	37 (74%)	13 (26%)	-	-	-	4.79
The activity enhanced my current knowledge base.	34 (68%)	15 (30%)	1	-	-	4.68
The educational material provided useful information for my practice.	35 (70%)	12 (24%)	3	-	-	4.75
The content was evidence-based.	42 (84%)	7 (14%)	1	-	-	4.79
Describe development of an ACEs training program for health trainees caring for adult patients	37 (74%)	12 (24%)	1	-	-	4.72
Describe the components of the Professional ACEs Informed Training for Health (PATH) model	38 (76%)	12 (24%)	-	-	-	4.76
Demonstrate case development and logistics of simulation in TIC training	36 (72%)	10 (20%)	4	-	-	4.64
Overall Mean						4.71

# SPEAKER OUTCOMES

## Dr. Martina Jelley, Dr. Julie Miller-Cribbs, and Dr. Fran Wen

In the evaluation, participants were asked if the webinar had motivated them to change their actions in their respective practice areas. The question asked: “Based upon your participation in this activity, do you intend to change your practice behavior?” Of the 50 evaluations, 29 (58%) indicated they intended to change their practice behavior. Of the 29, 14 (48%) intended to make one change, while the remaining 15 (52%) intended to make changes in multiple areas of their practice. The intended changes are noted below.



### Other Changes Indicated

- Incorporate ideas on training
- Incorporate ACEs into an existing sim
- Apply some of these concepts to our simulations for forensic exams

## SPEAKER OUTCOMES

### Dr. Martina Jelley, Dr. Julie Miller-Cribbs, and Dr. Fran Wen

Respondents were asked how confident they felt in making intended changes.

Respondents provided their rating on a 4-point scale: not confident, unsure, somewhat confident and very confident. Of the 29 who indicated they intended to make changes, 0 indicated they were not confident, 3 (6%) were unsure, 10 (34%) were somewhat confident, and 16 (55%) were very confident. Of the 50 evaluations, 21 (46%) indicated this item was not applicable.

Respondents were asked what they felt their primary barrier to implementing changes is. For this item, there were 29 responses. All identified barriers listed below:

Barriers	N	%		N	%
Time Constraints	6	17%			
Lack of Interprofessional Support	5	14%	Ability to make appropriate referrals	2	3%
Insurance/Financial Issues	4	21%	Patient Adherence	2	14%
System Constraints	10	31%	Treatment-Related Adverse Events	-	-

### Bias & Invitation Source

- There were 50 responses for the item measuring if attendees felt the presentation was free of bias. Of those, 49 (98%) agreed it was free of bias. The rationale for those who disagreed is unknown.
- 64 respondents reported how they learned of the event and completed an evaluation. The top sources of invitation were: Colleague email/word of mouth (9 or 14%), Received email from CIR, CAPSAC, APSAC, AVA (46 or 72%), ACES Connection (9 or 14%).

### Qualitative Data

*This was a great presentation and I'm hoping to implement additional training on responding to ACE scores*

*Thank you so much for this training. It was very informative.*

*More information on how to establish teams. Many of the presentations mention the use of teams members working together. Getting the medical community on board with using ACEs is especially difficult.*

*It was a great presentation as I work in Child Protective Services with many clinicians and providers in which are not always informed of ACES. Although I may not have a "practice", ACES and CANS scores are so pertinent to the work I do on a daily basis in assisting families dealing with childhood trauma especially in adulthood, and how they are parenting.*

*I am encouraged and excited by your program and the outcomes you are seeing. I look forward to seeing the results of the video interview coding as well as the results as your program moves along.*

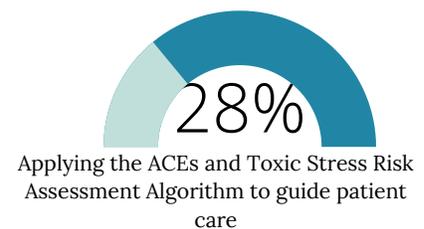
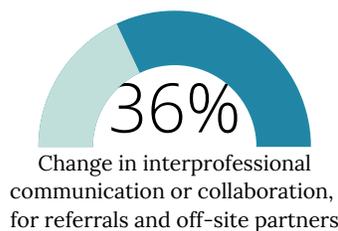
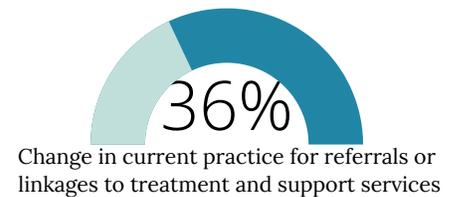
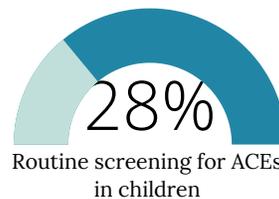
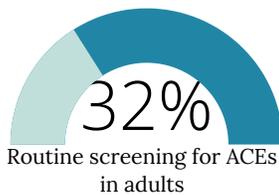
## Evaluation by Presenter

Dr. Sharon Cooper N=40	Strongly Agree-5	Agree-4	Neither Agree or Disagree-3	Disagree-2	Strongly Disagree-1	Mean
The presenter was effective in presenting the material	33 (83%)	6(15%)	1	-	-	4.88
The activity enhanced my current knowledge base.	33(83%)	6 (35%)	1	-	-	4.69
The educational material provided useful information for my practice.	31 (78%)	9(23%)	-	-	-	4.69
The content was evidence-based.	29(73%)	11(27%)	1	-	-	4.63
Participants will define and review examples of generational trauma based upon systemic racism and present discriminatory practices	34 (74%)	5 (10%)	1	-	-	4.69
Participants will discuss the consequences of discrimination against children of color	33 (83%)	6 (15%)	-	-	-	4.75
Participants will be able to explain the role of advocacy and anticipatory guidance for medical professionals to promote an expectation of equality for families and from service providers	33(73%)	6 (15%)	1	-	-	4.69
Participants will discuss steps that can be taken by healthcare providers to stand up for their parents who are fearful of retaliation by therapeutic or educational systems	32(80%)	7(18%)	1	-	-	4.75
Overall Mean						4.72

# SPEAKER OUTCOMES

## Dr. Sharon Cooper

In the evaluation, participants were asked if the webinar had motivated them to change their actions in their respective practice areas. The question asked: “Based upon your participation in this activity, do you intend to change your practice behavior?” Of the 40 evaluations, 32 (80%) indicated they intended to change their practice behavior. Of the 32, 11 (34%) intended to make one change, while the remaining 21 (66%) intended to make changes in multiple areas of their practice. The intended changes are noted below.



### Other Changes Indicated

- Promptly validate parents concerns for possible discrimination of any sort & use calls & letters to support
- Parent /families outreach /promote parental advocacy/education/insights

# SPEAKER OUTCOMES

## Dr. Sharon Cooper

Respondents were asked how confident they felt in making intended changes.

Respondents provided their rating on a 4-point scale: not confident, unsure, somewhat confident, and very confident. Of the 32 who indicated they intended to make changes, 0 indicated they were not confident, 0 were unsure, 16 (50%) were somewhat confident, and 16 (50%) were very confident.

Respondents were asked what they felt their primary barrier to implementing changes is. For this item, there were 47 responses. Barriers listed below:

Barriers	N	%		N	%
Time Constraints	6	15%			
Lack of Interprofessional Support	3	9%	Ability to make appropriate referrals	9	21%
Insurance/Financial Issues	4	6%	Patient Adherence	3	9%
System Constraints	15	33%	Treatment-Related Adverse Events	5	6%

### Other Barriers Indicated

- She is very effective as an African American M.D. advocating for patients. As a white woman, I don't have the same power, so outcome would be different
- Agency public policies (slow to promote change agent platform)

### Bias & Invitation Source

- There were 32 responses for the item measuring if attendees felt the presentation was free of bias. Of those, 30 agreed it was free of bias. One person who disagreed stated, "nothing is free of bias." and the other stated, "There are problems that various groups experience and have to deal with that aren't the results of systemic problems and that they must solve themselves."
- 33 respondents reported how they learned of the event and completed an evaluation. The top sources of invitation were: Colleague email/word of mouth (8 or 24%), Received email from CIR, CAPSAC, APSAC, AVA (18 or 55%), ACES Connection (7 or 21%).

## SPEAKER OUTCOMES

### Dr. Sharon Cooper Qualitative Data

*Wonderful, inspiring, and engaging presentation. Thank you so much. I would appreciate future training on how to broach the topic of ACEs with clients, as well as post-screening follow-up and interventions based on score.*

*The biggest issue at hand in Humboldt County is the lack of providers. Most medical or mental health specialist referrals need to travel 250 miles south to the Bay Area, which can be a roadblock for my patients who are low-income. Resources needed to attend to the social determinants of health are also limited.*

*It may not be appropriate for physicians to take on all school issues on behalf of parents. There are professionals and resources to take on the Districts and IEP contents. It helps to prevent a backlash. For instance, the IEP is a Federal document. The OCR-Education Division can guide the parent. For legal issues, Legal Aid and NAACP are resources. If the district is doing it to one student, it is likely to occur elsewhere in the system and needs to be stopped.*

*Excellent presenter.*

*Excellent presentation. I could listen and learn so much more, thank you from Scotland. Thank you for an excellent presentation. We are learning as a team and agency on how to change our culture to be racially equitable. Very challenging but we keep on keeping on. Although change is very minute, we are moving forward. Thank you again!*

## GENERAL FEEDBACK – QUALITATIVE DATA

At the conclusion of the evaluation, attendees were asked to provide any feedback they had regarding the scope of CAA, along with any general feedback for the presenters. The data across the series included insights into major themes across presenters, desires for future sessions, needs amongst attendees, and provide examples of what we have learned about the people in attendance in previous data. For example, there is a theme in comments expressing a desire for more information about how to best apply the information presented in the series in an interdisciplinary way, and those who have found ways to apply this information effectively within their respective scopes. For example, one attendee wrote:

*I work with adults in a justice setting so was probably not the primary target audience, however, I still found this training very informative and relevant to my work.  
Thank you for providing it.  
I have felt validated for my beliefs and interactions with the parents I worked with during my career*

The interdisciplinary nature of attendees is also reflected in their practice/work settings, and their requests for sector-specific information. Below are sectors represented in overall qualitative feedback identified through line-by-line coding:

- School-Child Welfare-Families-Intergenerational
- Critical Care Environment-Inpatient-ER
- Criminal Justice-Legal-Immigration
- Government

Also of note, in the evaluations of 7 of the 10 webinars, the topic of race was mentioned and partnered with a request for inclusivity of cultural considerations, tools for working with diverse populations, and research. For example:

*I'd like further presentations on how the ACES has been implemented with the Latino and Black populations including any studies done with this population with regards to the ACES.  
Thank you!*

*The intersection of systemic racism, homophobia, transphobia, xenophobia... on negative outcomes.*

# GENERAL FEEDBACK – QUALITATIVE DATA

## REQUESTS FOR FUTURE TOPICS

Throughout the feedback in evaluation sessions, requests for future training included:

- Use of psychotropic medications for PTSD/trauma
- Treatment modalities
- Training on how clinicians can have a conversation (comfortably) about sexual health with our tweens and teens.
- More on resilience and what strategies to help school-age children with developing resilience.
- It would be nice to have Howard Dubowitz present his SEEK program in a bonus webinar.
- Immigration and toxic stress
- ACES and Criminality
- Interested in ACES effects on students.
- Appropriate screening tools for various age groups
- Telehealth practices and ethics
- More treatment approaches for mental health providers using ACES in treatment of adults.
- Domestic partner abuse, covid and substance use, culture difference with covid, covid in other counties
- Leadership and organizational structures
- COVID Impacts
- Creating successful linkages between medical office and social legal agencies, ie courts, CPS, foster care agencies

## DISCUSSION

CALIFORNIA ACES ACADEMY (CAA) was originally designed to assist Medi-Cal providers to better understand the significance of ACEs, toxic stress, positive childhood experiences, resilience, and trauma-informed care to improve patient care, and to engage with community networks of providers who share these goals. The advent of the pandemic required adjustments to the program model and implementation plan. Despite the challenges posed, CAA was able to accomplish many of its initial goals and even more.

Several factors point to the overall success of CAA. The positive feedback from the evaluations communicates participant appreciation for the program. A wide variety of professionals attended the program, demonstrating CAA was meeting needs in many sectors of the community. The worldwide scope of participation served as a testament to the relevance and value of CAA across diverse communities and cultures.

The accomplishments of CAA were made despite the challenges presented by the pandemic and others. There was an ever-evolving landscape of changing requirements, guidelines, and process-related obstacles to meet grant requisites. The team was persistent, flexible, and committed to community building and education.

Lessons learned that can serve to improve such efforts in the future include recognizing the impact of global and local public health crises. Many Medi-Cal providers were serving on the front lines of the global pandemic while CAA webinars were being presented to the community. Recognizing the high demands on and unpredictable schedules of health care providers, CAA recorded all the live webinars, and made them available On-Demand with Closed Captions in English and Spanish at no cost. This increased the program's accessibility. Although CAA did not reach the hoped for number of Medi-Cal providers during the grant period, these free On-Demand webinars remain available, and further marketing could increase the numbers of Medi-Cal providers and others who will benefit.



Another possible explanation for the lower than hoped-for attendance of Medi-Cal providers may be reflected in the qualitative data of the evaluations. There was an observable pattern of respondents stating that another barrier for implementation of program principles was medical providers themselves. For example, one respondent wrote, "being seen as illegitimate by colleagues," and another wrote, "getting doctors on board," as their perceived barriers to change. Considering the two leading identified barriers to change across the program were time and system constraints, the perception of the ability to implement trauma-informed practices could impact participation in events by specific targeted audiences. It may be beneficial to identify further details about these barriers listed. For example, having a better understanding of what is problematic within systems and time could lead to opportunities for problem-solving or tailored tools.

The ability to target and reach a specific targeted audience is a challenge, and various approaches may be best combined to reach desired goals. For example, the majority of attendees in the program were female and behavioral health providers with the biggest barriers identified as "time" and "system constraints". Perhaps this illuminates a need for systems changes prior to seeing more individual changes in specific fields. If a more generalist approach is applied in an effort to capture whole systems of helping, having events and measurement tools less specific to practice will be needed. Conversely, developing specific marketing strategies to target populations may be valuable. Understanding the likelihood of different marketing strategies and the consideration of current influences on provider needs could help in identifying achievable goals.

There was an observed thread of information in what registrants were hoping for, the content of the program, and requested future topics for events. For example, there were parallels between the registration's question What drew you to participate in this event? and the evaluation's request for additional needs in future events indicating that while attendees found value in the program, there are other needs motivating their engagement. The webinars were rated very highly overall so events themselves were not insufficient, however, it may provide some insight into what professionals in the field are in need of to support them in their work.



One of those needs expressed throughout the program was the desire for culturally adapted materials and tools. The request for increased representation of diverse communities in research and training materials could also be the result of the COVID-19 pandemic in that it has illuminated disparities in healthcare and access to services.

Attempts to include webinars regarding race and cultural considerations were scheduled by the CAA team and denied approval by grantors. This challenge is also related to understanding the needs of the community of providers as well as those they serve. A potential solution to this request in particular as an example would be to ensure consideration of diversity in all events rather than a specific subset.

Similarly, approaches for team building and other interdisciplinary approaches were requested. This is reflective of the interdisciplinary nature of attendees and can be recognized as an opportunity to bolster systems around the targeted audiences.

Overall, it is the evaluators' impression that CAA successfully attained many of its goals. CAA nimbly adapted to challenges and demonstrated resilience, innovation, and determination to reach wider audiences than anticipated, and received close to the top evaluation scores possible. The consideration of the contents of this report may only serve to strengthen what has proven to be a successful method of reaching helping professionals with valuable information, and the communities they serve.

