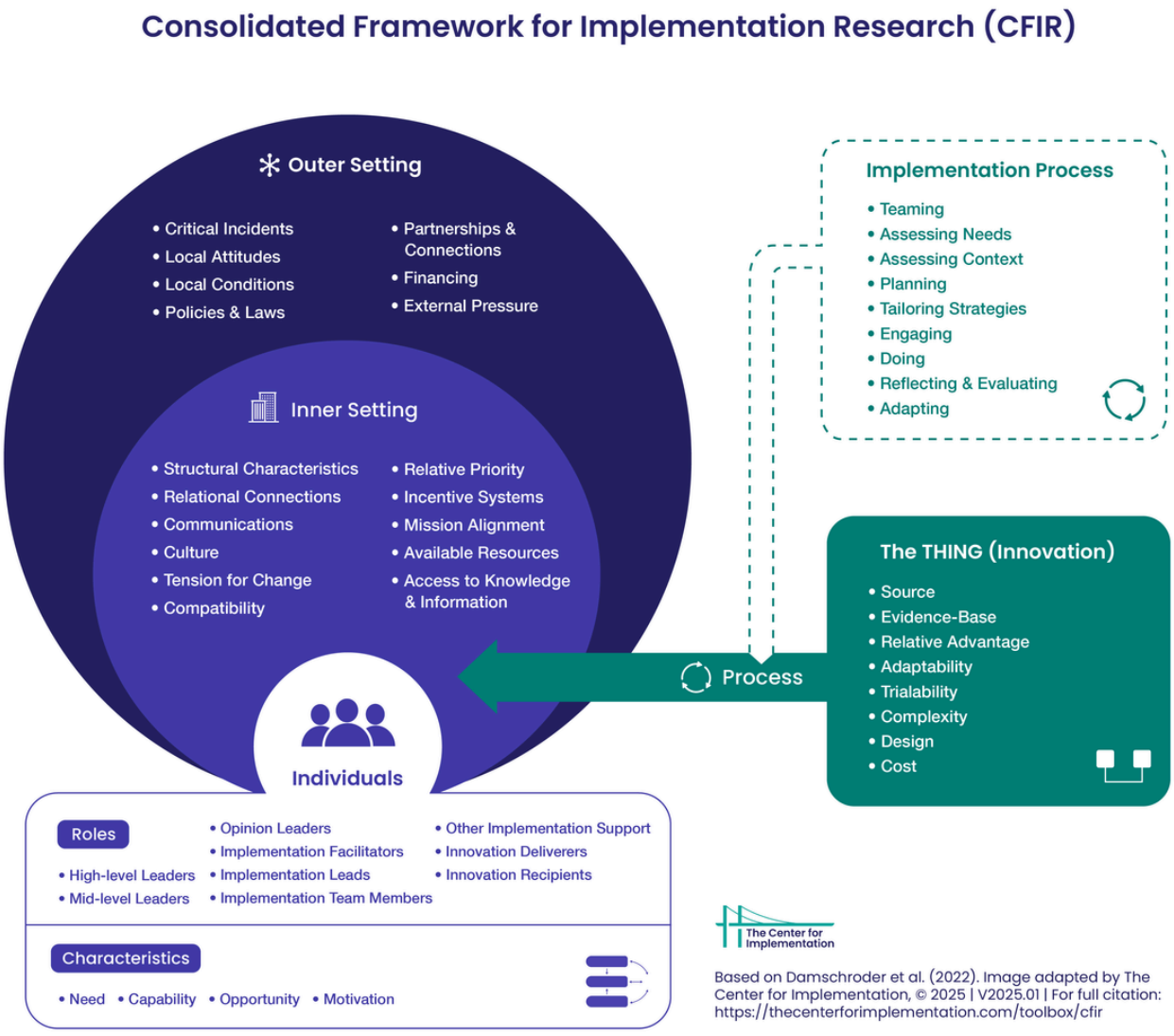
Applying the CFIR Framework: Case Reports of HOPE Implementation

Introduction

Positive childhood experiences (PCEs) are increasingly recognized as essential for lifelong health and well-being.[1-4] The Healthy Outcomes from Positive Experiences (HOPE) framework describes four core building blocks that promote resilience and mitigate the impact of adverse childhood experiences (ACEs): nurturing *relationships*, safe *environments*, *engagement* and belonging, and opportunities for *emotional growth*.[5] The HOPE National Resource Center (NRC) supports implementation of this framework across child- and family-serving systems.

To understand how the HOPE framework is adopted in diverse settings, this paper applies the Consolidated Framework for Implementation Research (CFIR) to four real-world implementation cases. CFIR is one of the most widely used implementation frameworks and organizes factors affecting implementation into five domains.[6] The *innovation* domain includes the intervention, including source, evidence base, relative advantage, adaptability, trialability, complexity, design, and cost.[7] The *outer setting* domain refers to the economic, political, and social context, and includes macro-level constructs such as critical incidents, local attitudes, local conditions, partnerships and connections, policies and laws, financing, and external pressure.[8] The *inner setting* includes the implementing organization and related constructs such as organizational structure, relationships, connections, communications, culture, tension for change, compatibility, relative priority, incentive systems, mission alignment, available resources, and access to knowledge and information. The *individuals* domain encompasses two subdomains: roles and characteristics. *Roles* refers to the capacity of each person involved in implementation across both the inner and outer setting. This may include formal and informal leaders at all levels, implementation team members, support staff, and those who benefit from the implementation. The characteristics subdomain describes the attributes of the individuals involved with implementation, including need, capability, opportunity, and motivation.

Finally, the *implementation process* includes specific activities and strategies, including designating a team, assessing needs and context, planning, tailoring strategies, engaging, doing, reflecting and evaluating, and adapting. Based on the identified facilitators and barriers, organizations can utilize differing implementation strategies.[9]



CFIR 2.0. Adapted from Damschroder, L. J., Reardon, C. M., Widerquist, M. A. O., et al. (2022). The updated consolidated framework for implementation research based on user feedback. Implementation Science, 17, 75. https://doi.org/10.1186/s13012-022-01245-0. Image adapted by The Center for Implementation, © 2025. Version: V2025.01. https://thecenterforimplementation.com/toolbox/cfir

The HOPE framework is intentionally adaptable to the local and organizational context and can be implemented in small, measurable ways. To support adaptation while maintaining clarity, HOPE NRC outlines five core areas of implementation: training, internal organizational culture, forms and policies, physical and virtual environments, and funder priorities.

In the sections that follow, we present five case studies of HOPE framework implementation across different settings and sectors. Each case references all five CFIR domains but highlights one in depth. This format offers implementation science practitioners a structured lens through which to understand the diverse and flexible ways HOPE is being used to promote PCEs, while also helping those doing the work see how their efforts align with a formal implementation framework.

Case Study: Tufts Pediatrics

HOPE Framework Core Areas of Implementation: Environment, Training, Forms and Policies

Site Context

Tufts Medical Center is a large academic medical center located in Boston's Chinatown neighborhood. In the wake of the COVID-19 pandemic, the Pediatric Primary Care Clinic sought to strengthen family resilience and improve clinic experience.

Goals of Implementation

Specific goals of HOPE framework implementation included:

- Increasing staff understanding of HOPE (training)
- Enhancing the physical environment of the waiting area (environment)
- Creating a child-friendly "Building Blocks" worksheet (forms and policies)
- Updating the clinic's late policy to be more family-centered (forms and policies)

CFIR Domains in Practice

- *Innovation – Small Changes to Increase Buy-In*: HOPE was seen as having strong adaptability and trialability. The team began with a few small changes (e.g., wall art, worksheet pilots), which helped build confidence and buy-in.

- *Inner Setting – Pediatric Primary Care Clinic:* The pediatrics clinic's inner setting – its departmental structure, leadership, and team dynamics – was the primary focus and facilitator of HOPE implementation. The clinic's general pediatrics division demonstrated strong mission alignment with HOPE's values of health equity and family-centered care. Division leaders created multiple opportunities for HOPE-related training and conversations in staff meetings. They also encouraged input from staff across roles, building relationships and interest in change around improving the clinic's environment post-pandemic. The buy-in of decision makers allowed for relatively rapid implementation; variation in staff familiarity with HOPE required tailored supports and ongoing engagement

- *Outer Setting – Tufts Medical Center:* The larger Tufts Medical Center environment was supportive of innovation. As the home of the HOPE NRC, the organization had built-in access to expertise and training.

- *Individuals – Multi-level leaders:* High- and mid-level leaders played an essential role in building staff awareness and motivation. Some frontline staff were unsure how HOPE applied to their role, which required ongoing support.

- *Implementation Process – Intentional Pacing:* The process was intentionally paced. Leaders introduced changes incrementally to allow time for reflection and adjustment.

Implementation Activities

- Administered a team self-assessment of knowledge of PCEs and knowledge and application of the HOPE framework.
- Conducted ongoing HOPE framework training to address the various levels of staff knowledge and assist staff in applying the framework to their role.
- Reinforced HOPE learnings in standing meetings through adding it as an agenda item to remind clinicians of the implementation goals and offering refreshers as informal spaces for staff to share their experiences on how they have incorporated HOPE and develop new ideas.

- Aligned child- and family-facing materials with the HOPE framework, including painting welcoming murals, displaying framed art from local elementary school students, and designing a community corner, with gently used resources (e.g., children's clothing), for family use.
- Piloted worksheets that children completed at check in to describe their experiences with the Building Blocks and that provided a starting point for discussion with their pediatrician about PCEs.
- Updated the clinic's late policy to be more understanding and accommodating for families.
- Included HOPE in their quality improvement activities, conducting two quality improvement cycles.

Outcomes

To assess the impact of the changes implemented, the pediatric clinic conducted focus groups with caregivers, staff, and organizational leadership. Caregivers were invited to participate if their children were currently being seen at the clinic and were asked about (1) their exposure and access to PCEs through being a patient at Tufts and (2) the relationship with their providers. They reported a strong sense of belonging and specifically felt more trust in their relationship with the providers, validated and affirmed in their care for their children, and believed that the waiting room changes had a positive impact on their overall experience.

Staff members were asked about their experience with implementing the changes and the impact they believed their changes had on their job satisfaction. They reported that they believed they were empowering families and were experiencing fewer symptoms of burnout. Organizational leadership reported that they had seen improvements in staff morale and intentionality in interactions with families. Leaders also expressed that they had added continued implementation of the HOPE framework to their organizational goals.

Case Study: Spokane Regional Health District

HOPE Framework Core Areas of Implementation: Training, Internal Culture, Forms and Policies

Site Context

Spokane Regional Health District (SRHD) serves Spokane County, Washington and employs approximately 250 staff across multiple divisions. During the COVID-19 pandemic, the Community Health Division launched an initiative called Beginnings Matter, to strengthen maternal and infant health efforts amid rising burnout and workforce instability. After discovering the HOPE framework at the 2021 HOPE Summit, leaders within the Beginnings Matter team introduced the framework first within the Nurse-Family Partnership (NFP) Program, a home visiting program where registered nurses provide support and information to families from pregnancy through 24 months, and later expanded its use across the division and into the broader community.

Goals of Implementation

Their HOPE framework implementation included:

- Increasing staff knowledge and language around PCEs and the HOPE framework (training)
- Disseminating knowledge about PCEs and the HOPE framework in the community (training)
- Supporting team cohesion and internal culture in the wake of COVID-related burnout (internal culture)
- Embedding HOPE-related language and concepts into organizational policies and practices (polices and forms)

CFIR Domains in Practice

- *Innovation – Low-Cost Dissemination:* The HOPE framework's adaptability allowed staff to personalize it for different families, and its low-cost nature made it feasible during resource-limited periods. In joining the HOPE Train the Facilitator program and training individuals to disseminate information about PCEs and the HOPE framework more broadly, SRHD was able to increase community buy-in.

- *Inner Setting – NFP Program:* Within the inner setting of the NFP program, preexisting relationships and connectedness between nurses and the creators of Beginnings Matter facilitated capacity-building and implementation of HOPE-informed changes. Another facilitator included the tension for change, as the staff felt the current level of burnout was untenable and were interested in a solution to address it. One notable barrier was available resources; there were concerns for the staff time and funding that would be needed for successful implementation.

- *Outer Setting – SRHD:* SRHD's implementation of the HOPE framework was shaped significantly by the outer context of the COVID-19 pandemic. Widespread burnout, staff turnover, and strained public health systems created both barriers and urgency for change. Amid this environment, the HOPE framework was seen as a promising, strengths-based tool to re-engage both staff and the community. The community-wide stressors and regional attitudes around maternal and infant health, combined with an emphasis on trauma-informed care, created the conditions that allowed HOPE to take root. The Beginnings Matter team used this opportunity to introduce HOPE as a unifying framework that could reduce burnout and support long-term recovery from the pandemic's impact.

- *Individuals – Staff Champions and Families:* The implementation of these goals relied heavily on the motivation and leadership of individual staff members. The Beginnings Matter team and nurses in the NFP program demonstrated high motivation to reduce burnout and improve family relationships. Leaders acted as champions, and team members engaged in shared learning, discussion, and adaptation. Families also played an important role by providing feedback that shaped the implementation process, reinforcing a participatory, user-informed approach.

- *Implementation Process – Family Feedback Leading the Way:* The SRHD implementation team reflected and evaluated based on family feedback. Staff worked collaboratively to embed HOPE in the NFP program and then expanded to other departments in SRHD.

Implementation Activities

- Identified and prepared champions, or individuals trained to drive implementation and garner energy for the approach.
- Provided peer support to others looking to integrate the HOPE framework into their programs after initial implementation in the NFP program.
- Joined the HOPE Innovation Network (HIN), a learning community facilitated by the HOPE NRC. All HIN organizations were implementing HOPE at the same time, providing a useful source of collaborative problem-solving.
- Aimed to identify key performance indicators in their 2025 work plan to assess the integration of HOPE into organizational culture.
- Redesigned their client satisfaction survey to incorporate the HOPE framework.
- Supported positive community messaging and civic engagement through adoption of HOPE informed language.

Outcomes

Many positive results were reported in focus groups by NFP program participants, NFP staff, and the organizational leadership. Participating families indicated feeling understood, supported, and affirmed by the nurses implementing the HOPE framework. Similarly, NFP program nurses felt that the tenets of the HOPE framework were key in helping build trust between themselves and the families they served. Staff also found that they felt more refreshed and inspired at work, with a more positive outlook that they felt like they could offer practical solutions when dealing with trauma and less reported symptoms of burnout.

The organizational leaders at SRHD noted the relationship-building and the cross-program collaboration that developed within the organization as a result of implementing the HOPE framework. They also identified the framework as a key factor in their long-term programmatic planning and were committed to expanding implementation further. At the community level, more organizations are collaborating with SRHD to engage with HOPE, including a local school district and hospital system. There has been enough interest that the team has developed a community learning series where organizations will identify ways they can work together to enhance social connectedness in the community.

Case Study: San Diego YMCA

HOPE Framework Core Areas of Implementation: Training, Internal Culture

Site Context

The YMCA of San Diego County is the largest YMCA in the nation, serving nearly 400,000 people and employing over 4,500 staff. In 2020, the organization was seeking a cohesive, trauma-informed framework to guide youth development and staff training efforts. After attending an early childhood conference, leaders discovered the HOPE framework and identified it as a unifying and actionable approach that aligned with their existing priorities.

Goals of Implementation

- Introducing HOPE as a common language across departments (internal culture)
- Unifying fragmented trauma-informed care efforts under a strengths-based model (internal culture)
- Increasing staff knowledge and confidence in supporting families (training)
- Building internal and external partnerships to scale impact (internal culture)

CFIR Domains in Practice

- *Innovation – Addressing Diverse Communities:* The YMCA embraced the HOPE framework's adaptability to have a cohesive HOPE-informed approach that is applicable to all of the diverse communities the organization serves. The process of engaging, or attracting and encouraging participation with implementation, was a key facilitator and led to a diverse group of staff members to become involved with HOPE.

- *Inner Setting – San Diego YMCA:* The implementation of HOPE at the San Diego YMCA was shaped primarily by the organization's inner setting. Specifically, it has a strong culture of mission alignment, staff enthusiasm, and internal capacity for innovation. The HOPE framework brought coherence to existing practices while reinforcing values of relationship-building and strengths-based care. The size and complexity of the organization did pose challenges. Coordinating across departments required intentional communication and broad leadership buy-in. Despite these challenges, relational trust, internal champions, and shared vision supported implementation.

- *Outer Setting – Local Ecosystem:* A supportive local ecosystem, with aligned values and attitudes across partner organizations, facilitated regional uptake and collaboration.

- *Individuals – Implementation Leads:* At the individuals domain, the implementation leads, those who were leading the implementation efforts, were enthusiastic about and motivated by the work involved to implement the HOPE framework. the work. One barrier to overcome in such a large organization involved intentional and impactful coordination on tasks to formalize HOPE-related practices across departments despite different department needs and goals.

- *Implementation Process – Collaboration at All Levels:* The San Diego YMCA utilized several implementation strategies in their process. Specifically, they engaged with staff members within their organization and in the broader community to attract and encourage participation. A critical part of this was gaining leadership buy-in that HOPE should be integral to organizational culture and not another peripheral training. An implementation process barrier has been teaming as they try to formalize the HOPE-related practices across departments in a large system. While some standardization is helpful, a benefit has been the ability to adapt, as the YMCA feels HOPE can be made applicable across all departments and to the diverse communities they serve. As HOPE implementation continues, staff have reflected on the successes and developed ideas for the future, including creating short and consistent HOPE trainings that can serve as reinforcement and collecting and evaluating feedback from families.

Implementation Activities

- Developed and conducted educational meetings to share information about PCEs and the HOPE framework, both internally and externally with county health workers, staff from the child welfare system, and other local non-profits.
- Built a coalition of other organizations in the county with similar missions that could serve as partners in wider implementation processes, including San Diego State University.
- Promoted network weaving as a way for organizations in San Diego to share information and collaboratively problem solve.
- Created additional roles dedicated to HOPE implementation due to increased demand for HOPE training.
- Launched a train the trainer program to train community members as facilitators and champions of HOPE.

Outcomes

Implementation of the HOPE framework has brought positive results to the families served by San Diego YMCA. Families reported in focus groups that staff were supportive, attentive, and wanting to collaborate on challenges. They additionally felt that the daycare programs offered consistent access to the four building blocks of HOPE and thus were important for providing their child access to PCEs. The staff implementing HOPE shared that they felt more positive, satisfied, and prepared to support families after participating in the foundational trainings. They also recalled that the HOPE framework's focus on intentional relationship-building helped them build trust and better empathize with the families. Organizational leaders have also felt the effects of implementation on the broader scale, reporting that the implementation of HOPE has led to increased enthusiasm and cultural shifts in the organization. Leadership has begun to use HOPE to frame discussions around staff support and relationship building, and one department has added an assessment of the strength of family relationships to its performance evaluation. Additionally, HOPE has positively impacted staff morale as they feel empowered to support families.

Case Study: National Academic Detailing Project

HOPE Framework Core Areas of Implementation: Training, Forms and Policies, Environment

Site Context

In partnership with the National Association of County and City Health Officials (NACCHO), the HOPE National Resource Center piloted a clinician-focused training initiative using academic detailing (AD). This approach, a one-on-one educational strategy drawing on motivational interviewing, was adapted to introduce pediatric clinicians to the HOPE framework and guide them in integrating it into everyday care.

Goals of Implementation

Implementation goals included:

- Increasing pediatric clinicians' confidence in addressing PCEs and ACEs (training)
- Embedding HOPE-aligned practices into primary care conversations (environment)
- Encouraging a shift toward strengths-based, relational dialogue (forms and policies, environment)
- Using academic detailing to identify and overcome barriers to implementation (forms and policies, environment)

CFIR Domains in Practice

- *Innovation – HOPE through Academic Detailing:* AD is an educational strategy that has been used with clinicians for over forty years.[10,11] This brief, person-to-person style of education between an educator or "academic detailer" and clinician typically occurs in the clinician's office and draws on the principles of motivational interviewing and social marketing.[11,12] AD has been utilized most extensively for prescribing practices,[13,14] but has been effective in other areas as a stand-alone intervention or partnered with other quality improvement initiatives, including improving rates of colorectal cancer screenings[15] and blood pressure screenings.[16] While AD has been used in pediatric practices,[17,18] the evidence in this setting is more limited. Four key AD messages were developed to provide a structure for clinicians to incorporate PCEs into their interactions with families: (1) identify positive experiences and strengths, (2) ask about social determinants of health (SDoH), (3) assess how identified risk factors may be affecting the child's current health, and (4) explore collaborative, strength focused problem-solving interventions to address challenges. Selected AD sites were from Delaware, Indiana, Michigan, and Texas and a total of 48 clinicians completed all three detailing sessions.

- *Inner Setting – Pediatric Practices:* At the inner setting, pediatric practices, mission alignment was an important factor in clinicians persisting with implementation of the HOPE framework. When there was clear alignment, clinicians were more likely to believe the framework enhanced their current work. Work infrastructure was a clear barrier for clinicians, as many reported that they did not feel they had the time and/or ability to fully commit to implementation due to all their other responsibilities. More generally, some practices had supportive cultures and infrastructures that enabled integration of HOPE-informed practices with already existing approaches, while others struggled with time constraints and competing demands.

- *Outer Setting – Community Resource Mapping:* Local partnerships and available community resources shaped how clinicians were able to respond to patient needs. This influenced the practices' abilities to create a resource list for patients and make warm handoffs to referral sources.

- *Individuals – Pediatric Clinicians:* Academic detailers acted as facilitators of the implementation, and as such, their knowledge and ability to address barriers with clinicians were critical factors in the success of the implementation. Clinicians were the innovation deliverers, and individual motivation and confidence varied widely. Highly engaged clinicians made measurable shifts in practice.

- *Implementation Process – Recruiting Academic Detailers:* NACCHO put out a request for proposals to recruit academic detailers from four areas in the US to participate in a project where they were trained in HOPE and ACEs, provided individual and group AD to clinicians, and collected data on the AD sessions and practice change.

Implementation Activities

- Conducted educational meetings with the clinicians.
- Distributed educational materials developed specifically for this project including (1) a patient resource guide which included a list of local

resources, (2) an electronic health record resource, and (3) "Shift the Lens: Guide for Pediatric Primary Care" which provided clinicians an introduction to the science of ACEs, PCEs, and the HOPE framework, research on the effects of these childhood experiences and health outcomes, and suggestions for incorporating the HOPE framework into practice.

Outcomes

After the final detailing session, 29 clinicians responded to a survey to provide feedback. Most clinicians (76%) felt very or extremely confident in addressing risk factors for ACEs and improving access to PCEs with their patients. Twenty-eight (97%) clinicians reported that it is very or extremely important for clinicians to address risk factors for ACEs or other traumatic events with their pediatric patients as part of regular care. Clinicians were also invited to participate in a follow-up six months after the pilot program ended. When asked about any changes they made in their individual practice because of the pilot, clinicians mentioned asking more strengths-based and open-ended questions in patient interactions, providing more resources, and asking more about social determinants of health. Specific examples of practice-level changes included discussing PCEs at all annual physicals and stressing the importance of resilience as a skill. Furthermore, clinicians mentioned that including ACEs and PCEs in their discussions helped build rapport with patients and their families, and that adopting a strengths-based approach made their own experience more positive and enjoyable.

Conclusions

These four cases illustrate how CFIR can be used to understand the dynamic and flexible implementation of the HOPE framework across diverse settings. While each case emphasized a different CFIR domain – inner setting, outer setting, innovation, and implementation strategies – all five domains played a role in shaping implementation efforts and outcomes. Shared facilitators included strong mission alignment, relational trust, and structured opportunities for learning and collaboration. Common barriers involved limited time, resource constraints, and variation in individual or team readiness.

The core strengths of the HOPE framework – its adaptability, low cost, and alignment with positive developmental science – make it well-suited for implementation across a range of sectors. For those doing the work, the structured application of CFIR helps clarify how their efforts fit into a broader implementation framework. For implementation scientists, these cases offer insights into how CFIR applies in real-world, flexible settings. As the implementation of the HOPE framework continues to expand across systems and communities, frameworks such as CFIR can support more intentional planning, strengthen cross-sector partnerships, and help sustain meaningful practice change grounded in positive experiences for children, families, and staff.

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