

National Pediatric Practice Community on ACEs Pilot Site Program

Cohort 1 Final Evaluation Report
Center for Community Health and Evaluation

September 2019



Pilot Site Program

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NPPC
National Pediatric Practice Community

1 Program Overview

Program Overview

The National Pediatric Practice Community (NPPC) on ACEs was started by the Center for Youth Wellness (CYW) to support professionals interested in applying ACEs and toxic stress science to pediatric practice and shaping the field of trauma-informed medical practice. To date, more than 1,000 individuals have joined the virtual practice community. The NPPC pilot program was created in 2017 to better understand the experience and process of integrating ACEs screening into pediatric clinical settings by working closely with a small group of practices in varied settings.

Pilot Sites

NPPC supported six pilot sites of various sizes, five in California and one in New York City. Sites included a variety of types of service delivery settings—four federally qualified health centers (FQHC), one integrated health system, and one community hospital/academic medical center.

Sites were introduced to the NPPC in a variety of ways, with about an even split between sites where senior leadership were the driving force, and sites where an individual provider championed the opportunity. All sites noted a perception that trauma was high among their populations and saw ACEs screening as a way to improve patient care with a more systematic way to assess and address patients' needs. For two sites ACEs screening was part of a larger effort: in one case to address the impact of trauma and implement trauma-informed-care on a system level, and in another case the health center was involved in a research study to assess the acceptability of screening and effectiveness of parenting interventions.

Acknowledging that screening for ACEs is not yet standard practice in pediatric clinics in the United States, the NPPC pilot program was framed as a quality improvement endeavor using a plan-do-check-adjust (PDCA) framework with coaching and systems in place to monitor, reflect on, and formally document their experience and learning.

To accommodate sites' context, be responsive to current practice, and capture learning about how ACEs screening can be successfully implemented in different types of pediatric practices, sites were able to tailor the details of their implementation. With support from NPPC, they chose:

- Which ACEs screening tool and supplemental questions to use
- Which patients to screen and at what frequency
- How they distributed the work among the care team (e.g., who administered the screen, who interpreted the results, who interacted with patients and their families, who connected them to follow-up resources, who did data entry)
- What the workflow entailed (when and how the screen was administered)
- What constitutes a “positive” score and resulting follow-up approach, including whether the sites included symptoms as part of their scoring algorithm
- Which internal and external follow-up services and resources they provided, along with the process around referral and linkage

The table below summarizes the NPPC pilot sites, along with key screening details.

Organization	Pilot Site Description	Tool	Tracked Symptoms	Ages Screened, Frequency
Institute for Family Health (IFH) FQHC with 27 clinic sites, including several school-based health centers	School Based Health Center at Harlem Children's Zone's Promise Academy 2 <i>New York, Harlem</i>	Teen self-report version of ACE-Q core 10 questions + 7 suggested supplemental questions	No	13- to 18-year-olds annually
Kaiser Permanente Southern California, Downey (KP) Integrated health system with 12 clinic sites	Bellflower Clinic <i>California, Bellflower</i>	ACE-Q core 10 questions + 7 suggested supplemental questions	Yes	3- and 5-year-olds at annual well child visits
La Clinica de la Raza (LC) FQHC with 28 clinic sites	Fruitvale Village Pediatrics <i>California, Oakland</i>	ACE-Q core 10 questions + 7 suggested supplemental questions and 5 additional questions about behavioral health and physical symptoms	Yes	7-to 11-year-olds annually
Marin Community Clinics (MCC) FQHC with 3 clinic sites	Novato, San Rafael clinics <i>California, Novato and San Rafael</i>	Reworded and condensed version of ACE-Q	No	New patients under 12, 9-month and 30-month-old well child visits
Santa Barbara Neighborhood Clinics (SNBC) FQHC with 4 medical and 2 dental clinic sites	Goleta Neighborhood Clinic <i>California, Santa Barbara</i>	ACE-Q core 10 questions + 7 suggested supplemental questions + 1 question about experience with natural disasters	No	At 4-, 6- and 9-month visits, then annually Also screened parents at one point in time
Zuckerberg San Francisco General Hospital and Trauma Center (SFGH) Community hospital and academic medical center	Children's Health Center, Pediatric Integrated Behavioral Health Team <i>California, San Francisco</i>	Modified version of the ACE-Q, integrated with The Childhood Resilience Screener and The Edinburgh-3	Yes	1- to 12-month-olds, annually

NPPC Pilot Program Components

Phase 1:

Intensive six-month period where practices tested and refined screening implementation.

CYW provided:

- Staff training on ACEs
- Educational reference and promotional materials for professionals and patients
- QI coaching to support implementation, data tracking and reporting
- \$15,000 stipend

Phase 2:

An additional six months where NPPC helped sites embed and spread their screening practice as appropriate, including supporting systems for ongoing data tracking and monitoring

2 NPPC Pilot Site Progress

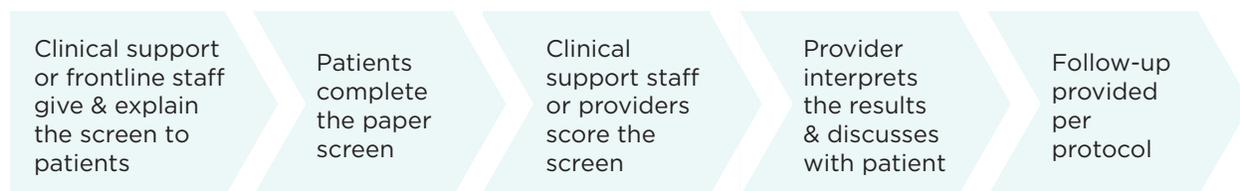
NPPC Pilot Site Progress

All six sites successfully implemented ACEs screening.

All six sites implemented ACEs screening during their six-month pilot period. **Across the cohort, over 1,900 children under the age of 18 were screened for ACEs.** As stated above, there were variations across the sites in how screening was implemented, including: scope of the pilot (i.e., target population determining the number of eligible patients, number of providers screening), screen scores that triggered follow-up, the extent to which symptoms were formally assessed as part of the screening process, and types of follow-up and referrals provided.

The number and role of the individuals involved in the screening process varied by clinic. However, there were a few elements of the screening workflow that were consistent across all sites (Figure 1). All pilot sites had clinical support or front-line staff hand out and explain the screening tool to patients. Either clinical support staff or providers scored the screen. Once the screen was scored, providers would discuss it with patients during their visit. There was general agreement across the sites that the interpretation of the score, symptoms (when included), and determination of level of risk and appropriate follow-up should be a clinical decision. Some sites had a clinical support staff member (e.g., care navigator, health educator) who would then discuss referral options with patients as appropriate.

Figure 1: NPPC General Screening Workflow



NPPC sites had between one and 18 providers implementing screening. There was not a consistent relationship between how many providers were participating, the number of patients eligible for screening and the number of patients screened. For example, one site with six providers screening reported results for fewer patients than sites with only one or two providers screening. This suggests that the eligible patient population was influenced more by the sites' patient population and the target population selected for screening.

Figure 2: The number of eligible patients ranged from 112 to 1,166.

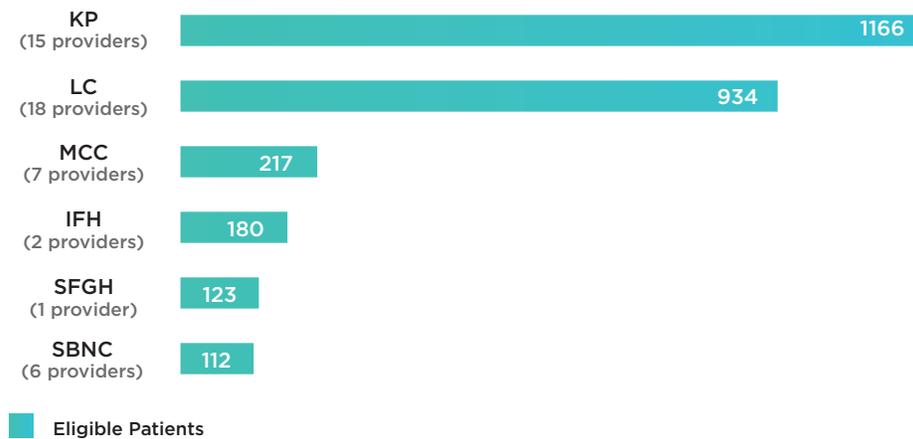
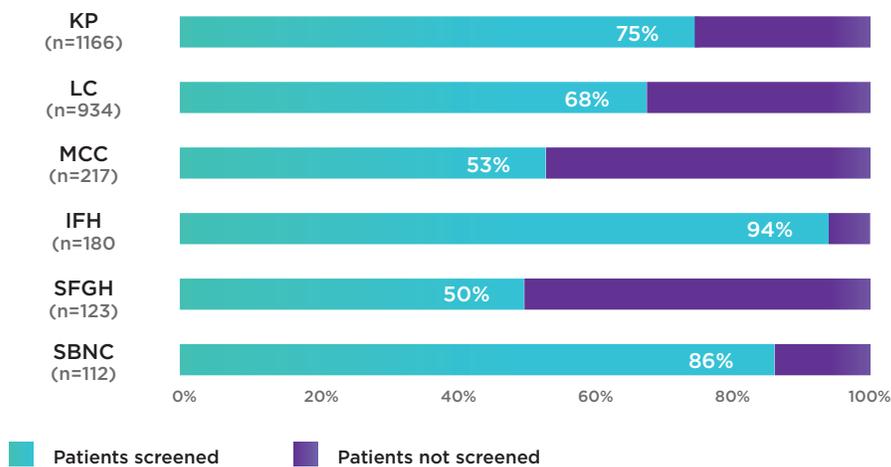


Figure 3: All sites screened at least one-half of their eligible patients. (n=# of eligible patients)



The percentage of eligible patients screened ranged from 50% to 94%, with most sites screening at least two-thirds of their eligible patients.

Clinics’ “positive” scores cannot be compared because they screened different age ranges, used different screening instruments, and defined a “positive” ACE score in a variety of ways (e.g., score of 2+, score of 1-3 with symptoms, score of 4+ with or without symptoms).

Most of the cohort (4 sites) had fewer than 20% of patients screen positive, while the other two sites had positive scores in about half of their screened patients.

There was a split among the sites in terms of referral to services—three referred about one-third of the patients with positive scores while two referred around three-quarters. One site (Kaiser Permanente) reported patients already receiving services along with patients referred.

**Figure 4 : Between 7% and 58% of screened patients had a “positive score.”
(n=# of patients screened)**

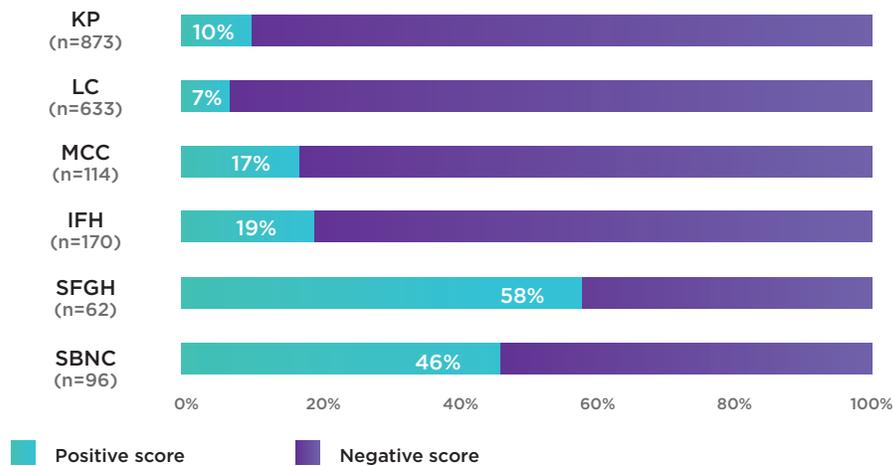
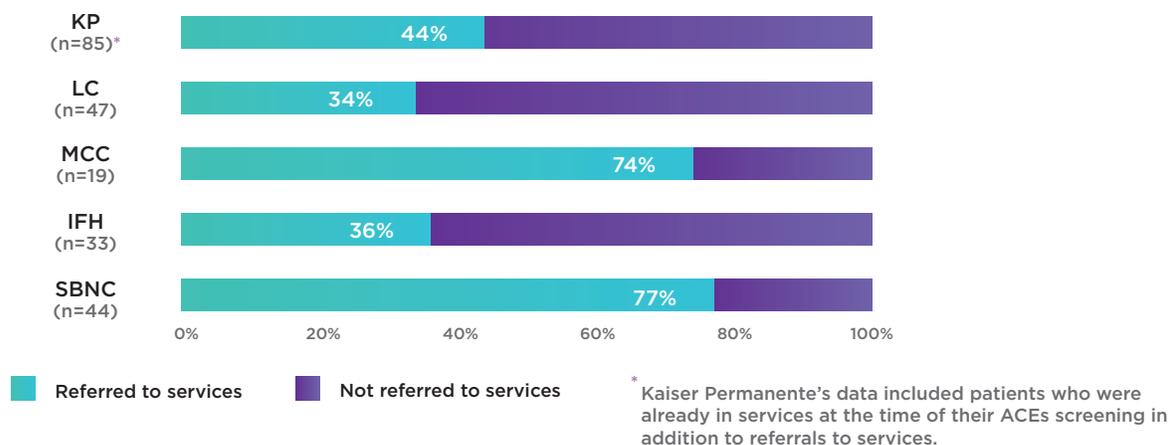


Figure 5: Around either one-third or three-quarters of patients screening positive were referred to services. (n=# of “positive” screens)



Sites reported various additional benefits resulting from NPPC pilot participation.

Sites and their staff were starting in different places in terms of how much exposure they had to ACEs prior to participating in NPPC. Some clinics had done a lot of education about ACEs with their staff prior to the pilot, and some were starting with low levels of familiarity with the topic. Being part of the pilot meant that the ACEs concept was more visible, providing exposure to a lot of other people (providers, other clinic staff).

All sites reported several other important outcomes including: increases in provider knowledge and comfort regarding screening, gathering results that helped them interpret patients’ symptoms and broadened their conversations with patients. In addition, all sites made some improvements to their data tracking systems in their electronic health record (EHR). Half of the pilot sites strengthened their referral networks to support patients’ newly identified needs. Finally, half of the clinics rolled out screening to other sites in their organization within the first six months of the pilot program, even though this was not an explicit goal during that timeframe.

Outcome	# of clinics ¹	Description of progress	Site example
Increased provider knowledge & comfort regarding ACEs screening	    	<p>NPPC staff trained over 170 staff and providers on ACEs² across the cohort. The number trained at each site ranged from 4 to 52 individuals, depending on the size of the organization and/or pilot site as well as the organizations' interest in training staff beyond those directly involved with screening.</p> <p>In post-training surveys, 85-95% of training participants reported some level of knowledge or confidence improvement from the trainings, especially related to concept of ACEs and toxic stress and understanding the need to address ACEs.</p>	<p>Some participants said the following was the most valuable:</p> <ul style="list-style-type: none"> • Explanation on how we can make our patients understand that we care about their problems. • Description to staff about science behind stress and its effects on health. • To be exposed to the larger network of NPPC. • The scripts that were provided for providers. • Understanding intervention planning and the difference between diagnostic vs screening tool.
Enhanced understanding of patients, which aided in symptom interpretation and treatment	    	<p>Most providers found screening useful to identify needs, aid in the interpretation of symptoms, learn more about the individual experience of patients and their families (especially new patients), meet patients and families where they were in the moment, build the therapeutic relationship and shared goals, and improve the quality of the whole person care provided.</p>	<p>At one site, a doctor connected the family history uncovered through screening with the four-year old's severely delayed speech development, and the parent was very open to exploring the connection. When the doctor sent the patient to a specialist, she included information about the relevant ACE and the specialist was very receptive as well.</p>
Broadened scope of conversation with patients, setting the tone around whole person care	    	<p>Sites found screening provided a neutral way to start an important discussion about patients' histories in a non-crisis situation, which made it smoother. Providers were able to introduce a conversation that wouldn't have normally happened, set a tone that the clinic cares about patients as whole people, and offer ways to understand and respond to related symptoms that might emerge in the future.</p>	<p>At one site the process of discussing ACEs with parents led providers to realize that postpartum mood disorders were more common than they had previously known. As a result, they began screening relevant patients more systematically and connecting them to appropriate services.</p>

1. These data are based on information from five of the pilot sites (excluding San Francisco General Hospital)

2. Post-training evaluations were administered in four of the pilot sites (excluding Institute for Family Health and San Francisco General Hospital)

Outcome	# of clinics	Description of progress	Site example
Strengthened data systems & capacity	    	<p>All sites reported strengthened data systems and capacity primarily through adopting changes in their EHR, although the specifics of these changes varied. Some sites built a best practice alert or shortcut to make it easy for providers to remember to document screening, including the ability to reset the reminder for the next appointment if the patient was too sick and screening was skipped. Other sites added functionality to track whether patients were referred to a service, were already in treatment, and/or were exhibiting ACEs-related symptoms.</p>	<p>At one site, integrating data tracking into the EHR was essential for organizational spread. By the end of Phase 1 of the pilot, the team had partnered with IT to develop a comprehensive template for tracking screening, results, and follow-up provided into the site's electronic health record, NextGen. They planned to pilot test implementation of the form during Phase 2.</p>
Improved referral networks & coordination	  	<p>The majority of sites strengthened their internal and external referral systems during the pilot program. This took a variety of forms: creating a new list of local external referral sources unique to each clinic site, embedding behavioral health providers in the pilot clinic, tightening coordination with their main internal and external referral sources, and adding a way to document referrals in their EHR.</p>	<p>At one site, clinical support staff made tailored lists of community resources to use for referrals for each of their locations.</p>
Spread screening beyond initial pilot clinics/ providers	  	<p>Even though the NPPC pilot program was designed to start small during the initial six months and spread during the next six months, two sites spread their screening practice to new providers or clinic sites earlier.</p>	<p>One site leveraged their internal network of child abuse prevention specialists to champion the introduction of the ACEs screener at additional clinic sites. Their regional structure and culture of innovation facilitated the spread. For another site, participating in the NPPC pilot helped launch them into doing trauma-informed-care work more broadly across their health center.</p>
Broader visibility of the health center in the community		<p>Participation in the pilot brought expertise, credibility and leadership around an important emerging topic.</p>	<p>One site reported getting positive media attention, new funders, and feedback that the public now sees the health center as innovative and effectively meeting patients where they are.</p>

3 Screening for ACEs in Pediatric Clinics: Lessons Learned

Screening for ACEs in Pediatric Clinics: Lessons Learned

Acknowledging that screening for ACEs is not yet standard practice in pediatric settings in the United States, the NPPC pilot program was framed as a quality improvement (QI) endeavor with systems in place to reflect on and capture lessons and insights along the way. In general, this approach worked for sites and partners throughout NPPC, which found that staying open to changing initial plans resulted in more innovative ideas and an ability to check and adjust to maximize effectiveness or mitigate problems. This allowed NPPC to meet pilot sites where they were starting and support them based on their organizational context and current practice. There is no one-size-fits-all approach for screening implementation; practices will need to make a variety of key decisions at various stages in the process, including training approach, screening and follow-up practices (e.g., tool, target populations, scoring algorithm, internal and external resources available), systems for tracking and reporting on data, and what stakeholder engagement and communication should entail.

While contexts and practices varied across the cohort, six key lessons emerged that we believe have broader applicability as more and more practices take on this work.

1 **Clear organizational alignment: sites benefitted when the NPPC pilot was well aligned with broader organizational goals and priorities.**

Sites were interested in providing the best possible care and support to their patients, and all initially reported that they perceived their patients to be frequently touched by trauma and anticipated high ACE scores. Beyond that, the reasons pilot sites gave for their interest in ACEs screening varied. For two pilot sites, leaders were very supportive because they saw screening as fitting in with a larger effort to make the organization trauma-informed. For two other sites, this pilot fit within a larger community focus on ACEs and was supported by partners outside of their organizations. Other motivations included:

- A hope that the pilot would establish new referral paths for patients to better address their needs.
- A funded continuation of a provider champion's interest in toxic stress.
- A path to clearly identify best practices related to screening and related interventions that will help the organization drive towards changing payment reimbursement structures.
- Aligning with goals around behavioral health integration and a strengthened network of partner organizations.

2 **Generating buy-in: Clinics found it was important to involve all stakeholders early in planning and to build support among organizational leaders, providers, and clinical support and front-line staff.**

Organizational leadership support

All clinics reflected on the necessity of having leadership support, especially from individuals with the power to clear calendars and grant administrative time to providers in order to focus on this work. One clinical champion worked hard to get the leaders in her large health system on board, attributing her eventual success to persistence and willingness to compromise on the details of the pilot, such as the age groups to be screened.

When leaders realized at the end of the pilot that the quality improvement summary drafted by the NPPC coach from the screening pilot could be used for other organizational priorities (e.g., patient-centered medical home designation, joint commission accreditation), they were excited and interested. One organization leader was so convinced of the organizational value that they allowed their clinical champion to maintain her administrative time for this project even after the stipend from NPPC was exhausted.

“ I worked hard to get leadership on board with screening, not taking no for an answer. I found talking about the long-term effects of ACEs for children and health care generally was very compelling. It also helped to emphasize that the screening helped providers diagnose people. I reminded them that you need to do the right thing even if it takes more time.

Kaiser Permanente staff member

Provider support

Even when organizational leadership support is in place, generating the buy-in of provider champions or early adopters is essential. Integrating ACEs screening, like other new screening practices, tends to be more effective if supported by a dedicated clinician with some funded time to devote to the work. Each participating clinic designated a provider to “champion” the process for integrating screening into existing clinic systems. This model reportedly worked well and was a key success factor, especially when that provider was seen in the organization as an authority on ACEs or related issues.

Several factors were reported to support provider buy-in for ACEs screening, including: previous training on the topic, a current focus on social determinants of health, familiarity with similar workflows for other screening processes, having a project manager or clinical staff support, and working with a patient population that already believes stress can make you sick. Additionally, knowing that their diagnostic practice is typically supported by the additional information that ACEs screening provides helped with creating buy-in.

“ We were reassured to learn that screening wasn't going to uncover a lot of hard things and bog down the system, but that it's another tool to help you understand your patients.

La Clinica de la Raza staff member

Clinical support and front-line staff support

How sites established buy-in among their staff varied, including making sure the team in charge of the pilot represented the staff that would be implementing the screening. A few clinics found the buy-in of their front-line staff was very high, which they attributed to many staff coming from the community that the clinic serves and so wanting to support efforts to take care of the community. Receiving training and feeling involved and aware of the reasons behind the new screening practice also helped garner support.

“The only way to demonstrate that everyone is behind and supports an initiative like this is to have everyone trained so they understand their role and what is happening.”

La Clinica de la Raza staff member

3 Providing training: Training at all levels helps build buy-in for and confidence critical for effectively implementing ACEs screening.

The amount of exposure to ACEs that providers and clinic staff had prior to the NPPC pilot varied widely across the sites. Even among those with some level of training and expertise in ACEs, providers reported experiencing some level of discomfort and trepidation about having conversations about ACEs with patients, which sometimes interfered with screening implementation. Peer support and training helped build comfort and confidence among providers, as well as clinical and frontline support staff responsible for administering the screening tool.

The NPPC pilot launched with training providers and staff involved with the pilot (at a minimum), and all the sites identified that as one of the most useful elements of the program. They also reported it was important that this training was provided by someone external to their organization and that it was professional and brought credibility to the effort. Sites also found that more training was needed as the screening practice was rolled out to additional providers and clinic sites. Leaders found that each site had different concerns, workflow challenges, and unique patient population issues to work through so benefitted from individualized attention.

4 Providing adequate follow-up: With appropriate scoring definitions and some attention to strengthening referral systems, NPPC sites were able to adequately respond to screening results.

While the experience of this cohort suggests that health centers will likely find their patient population's ACE scores are not as high as they expect, before implementing screening practices, clinicians should assess whether they have the internal and external resources needed for referrals and work to strengthen those networks if necessary.

When first considering implementing screening, many organizations and providers have concerns about not being able to appropriately follow up with all the patients who need it with appropriate internal or external resources. Across the wider NPPC membership group, this is consistently the highest rated concern. Similarly, respondents to the ACEs training evaluations at the beginning of the pilot period indicated lower levels of confidence related to discussing screening results with patients, providing appropriate follow up, and creating care plans based on results.

While all sites found creating a clear algorithm to guide providers in the scoring and referral process helpful, three sites spent some of their time and energy to improve their referral networks and coordination. One site found that it needed to research and create a list of locally relevant resources for each of their clinic locations. A few of the clinics worked, or plan to work, to create closer relationships between providers and the clinic staff with more knowledge of available referral sources (e.g., care navigators, health educators). Providers reported being comforted that patients were getting connected to needed services, even though some sites continued to face an internal and external behavioral services network that has limited capacity.

“
We learned you have to get providers and staff comfortable enough to do the screening a few times and then get them to realize that their big fears don't come to fruition.

Marin Community Clinics staff member

5

Electronic Health Record (EHR) integration: Building data tracking capabilities into the EHR early can help support implementation, embedding and spread of screening.

It is important to build data tracking capabilities into a clinic's EHR to catch implementation issues (e.g., eligible patients not being screened, patients refusing) and fully integrate the new screening process into existing practice and workflows. Building the right systems requires time and expertise, so bringing an information technology (IT) professional onto the implementation team early in the planning and design process was beneficial to pilot sites.

All sites built (or were working on building) custom fields and workflows within their EHR to facilitate the tracking of screening uptake. Sites varied in what they decided to track in their EHRs beyond the ACE score, including elements like: symptoms, referrals, screening refusals, and indicating when a patient was already in services or was too sick to be screened.

By the end of the pilot, four sites were able to successfully pull screening-related reports out of their EHR, while others encountered barriers that prevented them from pulling the relevant data from the system. IT professionals were engaged later in the project by four sites, at which point they found competing priorities and timelines delayed their ability to build what was needed for data collection and reporting. Sites reported that leaders look to data to better understand or demonstrate the value and effectiveness of screening. In the case where an efficient and effective data collection and reporting system was not yet built, there were concerns about the feasibility of sustaining and rolling screening out more broadly.

6 Patient experience: Overall, sites perceived that patients responded neutrally or positively to the screening and follow-up process.

Sites reported that patient responses to the new screening practice were generally positive, although not everyone wanted to talk about the experiences mentioned in the screen. A few sites believed that some clients under-reported their scores, perhaps because they were not ready to disclose or felt that the experiences were far in the past and no longer relevant. One site found that existing patients tended to share more than new patients who may not have yet developed a sense of trust with providers and their care team. Another site reported that screening was especially helpful for new patients or new providers, offering them the opportunity to get better acquainted and for the patients' experiences to be more deeply understood.

“Patients have become better advocates for their children, seeming to feel more empowered and comfortable to ask for referrals.”

Santa Barbara Goleta Clinic staff member

4 Next steps for ACEs screening

Next steps for ACEs screening

At the end of the initial pilot period, all sites reported planning to expand their ACEs screening practice either to other providers in the original clinic and/or to new clinic sites. Additionally, one site is developing a way to expand its screening to a population with high incidences of trauma and major language barriers that would best be served by a video or audio file to walk them through the screening tool. Multiple sites were also planning to add functionality to their EHRs to enhance their screening practice (e.g., documenting patients' symptoms or number/type of referrals made).

Sites that rolled out screening to additional clinic sites during the pilot period found that each site had unique workflows and cultures to consider when designing screening implementation. All affected staff and providers were supported by NPPC, which provided a training about ACE science and mapped out the details of their clinic's new workflow. Best practice may be to provide space for participants to discuss concerns and practice messaging with their peers as screening becomes integrated into practice.

5 Summary

Summary

NPPC successfully supported six diverse sites in implementing ACEs screening and 1,362 children under the age of 18 were screened during the initial pilot phase. Most sites also reported sustainably integrating ACEs into their practice, including making concrete changes in data systems. All sites reported that NPPC increased provider and staff knowledge about ACEs and built comfort with initiating related conversations with patients. Providers found that screening enhanced their understanding of patients and aided in symptom interpretation and treatment. They found that the scope of their conversations with patients was broadened, helping to set the tone around whole person care. For two sites, NPPC support during the pilot period helped them roll out their screening practice to other clinic sites in their organization, and all of the other sites had plans to expand screening to either other providers in the original clinic or to new clinic sites in phase 2.

Due to competing priorities for the team within SF General, their participation in NPPC was somewhat inconsistent and they were not fully integrated into evaluation processes. As a result, while the evaluation gathered information about the technical pieces of their screening process from the NPPC and other program documents, it did not have an opportunity to gather the team's reflections and lessons learned so data were not robust enough to compile a case study.

Since the practice of ACEs screening in pediatric settings is emerging, much can be learned from the work of this first NPPC cohort. Many of the lessons align with what it takes to do clinical quality improvement and practice transformation more broadly, including ensuring alignment with organizational priorities, building buy-in among leaders, providers and staff, providing appropriate training and support, and establishing electronic systems for data collection and early reporting. With some attention to strengthening internal and/or external referral networks and processes, NPPC sites were able to effectively respond to patients' needs uncovered through ACEs screening. Finally, sites found patients to be neutral to receptive to the conversations initiated through the screening process. These learnings will immediately influence the second cohort of NPPC's pilot program and may inform other clinical practices interested in implementing ACEs screening.

6 Appendix A: Evaluation approach and methods

Appendix A: Evaluation approach and methods

CCYW engaged the Center for Community Health and Evaluation (CCHE) to conduct the evaluation of the National Pediatric Practice Community on ACEs Screening (NPPC), including both the pilot program and activities related to the broader practice community. The evaluation has two goals: 1) to assess progress and impact on screening practices; and 2) capture lessons learned to inform program improvement and contribute to the field more broadly. The evaluation is focused on answering five questions:

1. To what extent has the NPPC **increased participants' awareness and knowledge** related to ACEs screening and appropriate follow up?
2. To what extent has the NPPC **changed participants' practice** related to ACEs screening and appropriate follow up?
3. What has been the **broader impact** of NPPC:
 - a. On patient care
 - b. On broader pediatric practice
4. What are the **lessons learned** about ACEs screening from providers/sites participating in NPPC, including reported barriers/ facilitators to ACEs screening?
5. To what extent has the NPPC program been successfully implemented? What has been the relative contribution of different components of the NPPC program?

CCHE used a mixed methods approach, including both quantitative and qualitative data to evaluate the first cohort of the pilot program. Data collection methods are detailed in the table below.

Data collection method	Purpose	Sample
Pilot site visits	Meet with the pilot site core team. Document site context, current screening processes, and observe programmatic activities (e.g., in-person coaching, training)	n=10 1-3 visits per site (1-2 days each) (SFGH excluded)
ACEs training post-event survey	Trainings conducted one time per site at the beginning of the pilot period. Document participant changes in awareness, knowledge & confidence related to screening. Gather satisfaction data on training content, structure, and presentation.	Paper evaluation from completed on paper by participants at 4 sites. (IFH and SFGH excluded) KP: n=11 LC: n=25 MCC: n=38 SBNC: n=93 Total: n=167
Pilot site interviews	Collect structured qualitative data on site context, process, outcomes, and experience with the NPPC at the end of Phase 1.	1-hour interviews with 1-5 representatives (individually or collectively). (SFGH excluded) n=7
Initial site visit planning calls	Observe site visit planning calls to document site context, rationale for participating in NPPC, and baseline screening practice.	n=6
Document review	Review site applications, coaching notes, and sites' monthly quantitative data reporting to document site context, screening process, and results.	N/A
Reflective discussions with NPPC program staff and coach	Gather program staff and coach impressions of sites' progress and themes related to key outcomes and lessons learned	Bi-annually (formally) Ad hoc (informally)

Analysis

CCHE used a case study methodology to understand and track progress at each pilot site. For qualitative data from interviews and observations, we conducted thematic analysis to identify commonalities across the cohort. Quantitative data (e.g., post-event surveys, monthly data reporting) was analyzed with support from Excel for basic descriptive statistics when appropriate.