

Annual Report
State Screening, Brief Intervention & Referral Project
Arizona Department of Health Services
August 1, 2010 – July 31, 2011

1. Executive Summary

A. Project Summary Statement

The Arizona Department of Health Services, Bureau of Women’s and Children’s Health has integrated alcohol screening and brief intervention within its statewide home visiting program, Health Start. The project was first piloted in Option Year One (OY1-8/1/2008-7/31/2009) in North Country Healthcare Community Health Center in Coconino County in northern Arizona and in Native Health Community Health Center in Maricopa County in central Phoenix. The project was expanded and integrated within the Health Start Program at eight local delivery sites in Maricopa, Coconino, Apache, Santa Cruz and Yuma Counties, reaching approximately 697 at-risk women during the Option Year Two (OY2 – 8/1/2009-7/31/2010). During Option Year Three (OY3 – 8/1/2010-7/31/2011), the FASD prevention project was integrated statewide at the remaining five Health Start sites for a total of thirteen sites, reaching over 996 at-risk women. The goal of the project is to eliminate alcohol consumption among pregnant women participating in the prenatal care program who are at-risk for poor birth outcomes. The strategy being integrated to accomplish this goal is implementation of the evidence-based intervention: M.J. O’Connor and S.E. Whaley “Brief Intervention of Alcohol Use by Pregnant Women (*American Journal of Public Health*, 2007; 97 (2): 252-258). The target audience at the local delivery sites is predominately Native American and Hispanic pregnant women at high-risk for a preterm birth as determined by medical risk factors and social risk factors identified at enrollment. The FASD prevention project supports the Bureau’s mission “to strengthen the family and the community by promoting and improving the health status of women, infants, and children.”

B. Needs Assessment

Needs assessment methods consisted of analyzing reported information from Health Start Program data collection forms, analyzing demographic and health status data, collecting data from local service delivery sites and conducting public input sessions. The FASD Prevention Project conducted public input sessions in April 2008 to gather data and information from clients and providers at North Country Health Care and Native Health Care. Education and training surfaced as major needs among internal and external providers.

The population is at high risk for alcohol use. Alcohol use and tobacco use were reported as prenatal risk factors for 7% of program participants (ADHS Health Start Data Report, 2007). Prenatal alcohol exposure is high since more than half of pregnancies are unplanned and 53.1% of women report current alcohol use (SAMHSA, 2006). In 2007, 25 cases of fetal alcohol syndrome were diagnosed among hospitalized infants less than 1 year of age in Arizona (ADHS, 2007). In 2009, 277 women self-reported drinking while pregnant and 199 reported smoking and drinking while pregnant out of 92,616 births (Health Status and Vital Statistics Report -ADHS, 2010). Only 3 babies were reported born with fetal alcohol syndrome in 2009. The payee for two of the deliveries was the Arizona Medicaid system called the Arizona Health Care Cost Containment System (AHCCCS) and 1 delivery was by the Indian Health Service (IHS). The mother’s age group was from age 20 – 39 years. Information about maternal drug use during pregnancy is not reported on the Arizona Birth Certificates but can be obtained from hospital discharge data. In 2009, 990 newborns were hospitalized after birth due to exposure to noxious influences affecting the fetus (AHDS 2010). Sites report high usage of substances among their enrolled clients. Even though alcohol use is listed as a medical risk factor for program eligibility, sites report that women are reluctant to disclose use at enrollment. Client disclosure of alcohol use would more likely occur after several visits between the Community Health Worker and client. The training and education of Community Health Workers was identified as a need to ensure effective administration of the screening

tool and brief intervention. Findings also indicated a need for culturally sensitive materials and easy to understand data collection instruments. Overall, findings clearly demonstrated the need for the FASD prevention project and the willingness of sites to implement the screening and brief intervention with their clients. The first year actual project results indicated that 29% of the women screened were eligible for the brief intervention and the second year actual project results revealed 25.1%. The third year actual project results indicate 19.7% of the women screened eligible for the brief intervention; a major decrease from OY1 and OY2. This was much lower than the expected (50%), as well as the O’Conner and Whaley study (23.8%).

C. Strategy

a. Objectives

The original outcome objectives of the Arizona Screening and Brief Intervention Project for the period of August 1, 2008 through May 31, 2012 were revised based on Option Year One (OY1), Option Year Two (OY2) and Option Year Three (OY3) results. The revised objectives for August 1, 2011 – May 31, 2012 are listed below:

	OBJECTIVE 1	OBJECTIVE 2	OBJECTIVE 3
WHO	Pregnant women who drink and are enrolled in the Health Start Program	All pregnant women enrolled in the Health Start Program	Children aged 0-2 of women who drank while pregnant and are enrolled in the Health Start Program
WHAT	Abstain from drinking alcohol during pregnancy from brief intervention to program exit	Abstain from alcohol during pregnancy from enrollment to exit of program	Reduce number of children aged 0-2 diagnosed with an FASD
HOW MUCH	100% of women who at the first prenatal visit report drinking alcohol	100% (965) of pregnant women	100% decrease in number of children 0-2 diagnosed with an FASD
WHEN	At exit of program; by January 31, 2012 and May 31, 2012 (and biannually each year thereafter)	At exit of program; by January 31, 2012 and May 31, 2012 (and biannually each year thereafter)	At exit of program; by January 31, 2012 and May 31, 2012 (and biannually each year thereafter)

b. Target Audience

The target audience for the project is at-risk pregnant women enrolled in the Arizona Health Start Program. Women must meet the Health Start Program eligibility requirements, which include residing within the subcontractor’s service area and having at least one medical risk assessment factor and one social risk. Leading medical risk factors include but are not limited to mother less than 19 or over 35 years of age, previous birth complications, alcohol use, substance use, chronic diseases, anemia and depression. Social risk factors include depression, domestic violence, lack of family support and basic needs.

The FASD Prevention project selected two local services delivery organizations, North Country Health Care and Native Health, to implement the screening and brief intervention for the OY1. The FASD Prevention project added six more sites for a total of eight sites providing screening and brief intervention in OY2. The FASD Prevention project added the remaining five sites for a total of thirteen sites in OY3. The demographic characteristics from all Health Start Program participants indicate 69% are Hispanic, 17% are White, 11% are Native American, 1% African American and 2% Other; average age is 24 years. Most participants (65%) report their marital status as unmarried, 66% are on Medicaid, and only 31% are high school graduates. The project screened 996 women for alcohol use, of which 196 or 19.7% were eligible for brief intervention education in OY3.

c. Service Delivery System

The Arizona FASD Screening and Brief Intervention were integrated into existing Health Start Programs at two local service delivery sites during OY1. During OY2, six additional local delivery sites were added for a total of eight sites in five counties providing screening and brief intervention. The Arizona FASD Screening and Brief Intervention was successfully integrated into the remaining five sites during OY3 for a total of thirteen sites providing the intervention in ten counties. The Program serves pregnant women at risk for poor birth outcomes and their families, providing education, advocacy and linkages to medical and social services in their communities. Home or clinic visits are provided to enrolled pregnant women at least once per month by each site. The FASD prevention project will be integrated at any new local delivery sites added during OY4 as a result of an expansion effort to unserved areas through a Request for Proposal initiative. The current thirteen sites include eight local county health departments, three community health centers and two community based social services agencies. The thirteen sites reached women in ten counties and screened over 996 pregnant women for alcohol use during pregnancy during the third year, of which 19.7% screened eligible. The average age of the women at screening was 24 years, 65.1% reported their ethnicity as Hispanic, 14.5% reported their race as Native American, 81.6 reported their race as white, and 3.9% were other.

d. Combination of Methods

The BWCH integrated evidence-based strategies within the Health Start Program service delivery system to decrease the incidence of FASD by assisting pregnant women to achieve abstinence from alcohol. All pregnant women enrolled in the Health Start Program’s eight service delivery sites were screened for current alcohol use utilizing the modified TWEAK screening tool. If women scored positive on the screening tool for alcohol use, they were eligible to receive the Brief Intervention. The evidenced-based strategies will continue to be integrated through OY4. Women will be referred to treatment if it is determined that they need additional assistance to stop drinking during pregnancy.

D. Implementation Plan

The BWCH will continue to implement training and education on the alcohol screening process and brief intervention workbook for the staff at Health Start Program sites during OY4 as it did in the first month of OY1, OY2 and OY3. Implementation procedures and changes to the Policy and Procedure Manual for the program were initially completed by August 1, 2008 and updates were provided to local delivery sites during OY2 and OY3 as needed. The integration of the screening tool and brief intervention was successfully implemented at each site by August 1, 2008 and October 1, 2009 for the additional six sites and was implemented by October 1 at the remaining five sites. All prenatal clients enrolled in the Health Start Program will receive the alcohol screening, and those screening positive will receive the brief intervention. Data will continue to be entered into a database provided by Northrop Grumman. Analysis of the data will occur on a monthly basis with the FASD Subcommittee and Statewide Task Force. Potential problems anticipated include alcohol screening not being conducted on every prenatal client and the possible reluctance of clients at the first prenatal visit to disclose alcohol use or act defensively. Building rapport with clients was seen as the most amenable solution to the latter potential problem.

E. Evaluation Plan

The evaluation design will be prospective, using a longitudinal design measuring implementation processes and program outcomes at various intervals throughout the project period. Multiple measures should enable the evaluation to control for most threats to internal validity and approach valid causal inferences. The units of analyses will consist of individual-level (pregnant women and their children) and aggregate data (based on Health Start communities). This initiative ensures that the evaluation will be conceptually and procedurally integrated through two methods: A process and an outcome evaluation.

F. Concluding Comments

The FASD Prevention Project is needed in Arizona to decrease the prevalence of alcohol use and dependence among pregnant women and in turn decrease the incidence of FASD. The project clearly fits the mission of the BWCH since preventing women from using alcohol during pregnancy and thereby reducing FASD in children will improve “the health status of women, infants and children” in Arizona. The initiative will bring together other state agencies and resources through the existing Statewide Task Force on Preventing Prenatal Exposure to Alcohol and Other Drugs and the newly-formed FASD Prevention Project Team Subcommittee. Government research indicates the rate of FASD to be one out of every 100 births. This means approximately 870 babies are born each year in Arizona with a diagnosable FASD. The cost to Arizona taxpayers is estimated to be \$98 million every year with an estimated lifetime cost of one child of \$516,000. The implementation of the alcohol screening and brief intervention in all thirteen of the Health Start Program sites is an effective strategy to prevent alcohol-exposed pregnancies. The implementation of the screening and brief intervention has been a beneficial process that has increased the awareness of alcohol use among women of reproductive age. The local delivery site staff involved is recognizing the value of the project as they work with women and their families. Screening at the thirteen sites could potentially prevent eight or more babies being born with FASD. Prevention efforts will be strengthened through the development of state and local resources, which will assist in building more cost-effective practices and result in a reduction of the number of children with FASD and a significant cost savings to Arizona taxpayers.

2. Key Client Results Achieved

The Arizona FASD Screening and Brief Intervention (SBI) Project completed its second full year of screening beginning August 1, 2010 through July 31, 2011. The number of local delivery sites increased from eight sites to thirteen total sites, including eight local county health departments, three community health centers and two community based social services agencies. The project was successful in screening 996 women, higher than the OY3 projection of 945 women.

a. Target Population

The target population of the project includes at risk pregnant women who are enrolled in the Health Start Program. The Health Start Program in Arizona is provided in ten out of fifteen counties and serves over 100 communities. The OY3 revised projection was adjusted to 945 at-risk women with the integration of the project at a total of thirteen local delivery sites. This revised figure was based on the number of at-risk pregnant women enrolled at the thirteen local delivery sites over a period of three years, factoring in the decrease in the number of births annually in Arizona. The FASD prevention project will be integrated at any new Health Start local delivery sites added during OY4 as a result of an expansion effort to unserved areas through a Request for Proposal initiative. The SBI project will be integrated into new sites in OY4 which will increase the projected target population to 1,273 pregnant women.

b. Demographic Data

The demographic breakdown of the Health Start Program participants which includes both pregnant and postpartum women is 69% Hispanic, 17% White non-Hispanic, 11% Native American 1% African American and 2% other. The average age of all Health Start program participants is 24 years, 65% are unmarried, 66% are on Medicaid, and only 31% have graduated from high school (ADHS, 2007). The SBI project demographics vary somewhat from the general program data due to the geographic location of the thirteen local delivery sites and the fact that the project screens only pregnant women. Of the pregnant women participating in the project in OY3, 65.1% reported their ethnicity as being Hispanic/Latina, 81.6% reported their race as White, while 14.5% reported their race as American Indian, 2.0% African American, 1.6 % Asian, and 2.3% other. Initially during OY1, there were less Hispanic/Latina women and more Native American women participating in the SBI project. The representation of Hispanic/Latina

women increased greatly in OY2 and OY3, due to the addition of 6 sights in OY2 and the remaining 5 sites in OY3, which serve predominately Hispanic women. During OY3, due to the overwhelming need for screening among the Native American pregnant women, the local delivery sites made every effort to focus on serving that population by recruiting more women from the urban and rural reservation areas. Most participants in the project report their marital status as never married (34.0%) and unmarried (30.4%) or living with partner (30.4%). Of the women who reported, 31.7% stated they were married. The average age for project participants in OY3 was the same 24 years as that of the Health Start Program.

c. Screening

The FASD Screening and Brief Intervention (SBI) project thirteen local delivery sites screened 996 pregnant women in OY3. There were 196 women, or 19.7% who screened eligible for the FASD SBI program. Of those who screened eligible, 173 or 88.3% agreed to participate in the program. Twenty-three women (11.7%) either refused to participate or were not located to participate.

d. Baseline Characteristics among Women Who Qualified Based on Screener Score and Women Who Qualified Based on Past-30-Day Alcohol Use

Of the 196 women eligible for the brief intervention, 153 qualified based on screener score alone while 43 qualified based on past-30-day alcohol use. For those who qualified based on screener score only, in the 30 days prior to screening, the median number of days these women drank alcohol was zero, while the median number of drinks consumed on a typical day when drinking alcohol in the 30 days prior to screening was also zero. For the women who qualified based on the past-30-day alcohol use, the median number of days these participants drank alcohol in the 30 days prior to screening was one day, while the median number of drinks consumed on a typical day when drinking alcohol in the 30 days prior to screening was two. There were two participants who qualified based on screener score only who had 4 or more drinks in one day in the past 30 days at screening and 29 who reported 4 or more drinks in one day based on the past 30 day alcohol use. In each qualifying group, there were 4 women who were given one or more referrals to treatment for additional assistance to stop drinking alcohol.

e. Intervention Services among Women Who Qualified Based on Screener Score and Women Who Qualified Based on Past-30-Day Alcohol Use

There were 196 Health Start pregnant women qualifying for the brief intervention (BI) including 153 from screening scores and only 43 for past month use. During OY3, there were 83 women, or 72.8% who were provided or completed the follow-up form at 36+ weeks of pregnancy. This has improved greatly from the OY2 low of 11.7%. The increase can be explained by the additional trainings provided to sites, the monthly FASD Subcommittee Team updates and follow-up tables being provided to each site on a monthly basis. In addition, during OY3, there was a change in the data base by Northrop Grumman which modified the date of when the 36 week follow-up Form D's were being counted. This change also benefited the program, reducing the number of Form D's required for each client and therefore increasing the number of women that were documented completing third trimester follow-up. Providing each local delivery site with monthly tables of those clients that were due for a 36 week follow-up visits and discussing the process at each monthly meeting was a key factor in the compliance with providing the forms. The goal of reaching 80% compliance is likely to be accomplished in OY4 with continued follow-up with the local sites.

f. Alcohol Use Outcomes

Of eligible women who reported drinking alcohol on at least one day in the past 30 days at screening, there were 11 or 91.7%, who decreased alcohol use. One woman did not report a decrease. Of those eligible women who reported drinking 1 or more drinks on a typical day in the past 30 days at screening, there were 11 who decreased the number of drinks in the past 30 days or 100% of women who qualified. Of the eligible women who reported

having 4 or more drinks in 1 day in the past 30 days at screening 7 out of 8 or 87.5% participated in at least 1 BI session and completed the follow-up visit. Based on the results, 83 women (98.8%) who were eligible and participated in at least 1 BI session and completed a follow-up visit form in the third trimester reported no alcohol use in the past 30 days at program exit.

g. Alcohol Use Outcomes among Women Who Qualified Based on Screener Score and Women Who Qualified Based on Past-30-Day Alcohol Use

Of the eligible women who participated in at least 1 brief intervention education session, 11 out of 12 or 91.7% reported no binge drinking and no alcohol use in the past 30 days at program exit. This indicates that once the twelve women received the brief intervention most had not relapsed or admitted a relapse which would have required a second, third or fourth form E-process form, indicating another BI had occurred. There were zero responses from eligible women who participated in at least 1 brief intervention education session, and completed the follow-up visit form in the third trimester and who reported no alcohol use in the past 30 days on all follow-up forms after the second, third and fourth completed process Form E. The 1 client that may have reported at program exit that they had alcohol since the first session may not have received a second brief intervention. Education will be provided to the sites to correct this in the future.

h. Post Partum Follow-up

The post partum follow-up with eligible women who screened positive and completed the follow-up visit form at 36+ weeks and who agreed to have their record shared with the target child's physician total 78 or 94%. The first time this is asked is on Form E, the process form. After the birth of the child, Form G asks women again if they are agreeable to have the record sent to the child's physician. Five women, when asked again post partum were not agreeable and still remained defensive about revealing the information. Most of these women screened eligible based on TWEAK question seven. Of the eligible women who participated in a least 1 BI session, completed the follow-up visit form at 36+ weeks pregnancy, and agreed to have their record sent and then agreed again post partum to have their record sent was 16 or 20.5%. The sites have improved significantly in their approach with women to help them understand the importance of agreeing to have their record sent. However, the sites are not always following through with actually sending the letter to the physician to notify them of the outcome of the screening process. This will be addressed through further education in OY4. The Option Year 3 (OY3) Annual Report Tables are included in Appendix 1.

3. Program Description

a. Population Needs Identified and Addressed

The target population at each of the thirteen sites consists of all pregnant women enrolled in the Health Start Program. Pregnant women must meet the Health Start eligibility requirements; they must live in the local delivery site geographic service area and must meet at least one of the self reported risk assessment factors. Participation in the program is voluntary but highly encouraged for those who identify one or more of the risk factors. In OY3, there were very few specific needs of the population identified at the start of the project in July 21, 2009. The number of local delivery sites increased from the two pilot sites, North Country and Native Health, who served predominately Native Americans, to thirteen sites in 2010. The additional sites identified a need to have more screening tools and educational materials available in Spanish since three sites are geographically located on the border of Arizona and Mexico, Douglas, Nogales and Yuma. Spanish forms were distributed to those sites that needed them and additional educational materials such as brochures and posters were made available in Spanish or translated. The Final Eligibility Questions that were added to the newly revised Form C into Spanish became available and the revised forms were made available so that the Spanish screening tool matched the English version. The second need identified through the screening process was that there was clearly a lack of knowledge and overall misinterpretation of the impact of alcohol use on the fetus by women and their families and by staff at the sites. At least four local delivery sites, after attending several

trainings provided by ADHS, set up and provided their own classes on Fetal Alcohol Spectrum Disorders to their clients and families and to colleagues such as WIC workers at their site. Materials such as power points and handouts that are available through the www.samhsa.gov were provided to the local delivery sites so that they could conduct education of the topic area as needed. The third identified need was to address the introduction and phrasing of the screening process to the new prenatal client and to ensure that the process was culturally sensitive and that population accepted the process. This was addressed through the revision of the draft script for Community Health Workers to introduce the screening and monthly reminders that the BI needs to be provided to all eligible clients at the time of screening. Additional training was provided to the Community Health Workers on Motivational Interviewing (MI) by Dr. Robert Rhode from the University of Arizona for a second year in a row at the Arizona State University downtown campus. The MI training will be an ongoing yearly training provided to staff providing the SBI. The needs identified have not changed since the first time they were identified in OY2 however many of the sites are now more involved in mentoring the other sites that still struggle with the SBI integration.

b. Service Delivery Process

The service delivery process of the FASD SBI project is initiated at enrollment of a new prenatal client. All of the pregnant women enrolled in the Health Start Program at the thirteen sites are screened during the enrollment visit or at the next prenatal visit utilizing the Form C – Alcohol Brief Intervention First Visit Screening Questions with TWEAK three pages, two part forms. The enrollment visit may occur in the client’s home or at another location convenient to the client, which is most cases, is the office of the local delivery site. Integration of the screening was implemented as an added task for the Community Health Workers to complete during the already lengthy enrollment process which includes the signing of the Intent to Participate form, a risk assessment Enrollment Form, and an overview of the Health Start Program. Each local delivery site is responsible for outreach and recruitment of new prenatal clients on a monthly basis. Many sites obtain new clients through referrals from WIC, family planning programs; walk in pregnancy testing or from their own prenatal clinics offered through their community health centers. Many sites hold recruitment fairs and post information at local high schools, doctor’s offices, hospitals and clinics. If a prenatal client screens eligible for alcohol use and when provided the brief intervention education reveals a score of four or greater and/or indicates a low level of confidence of being able to stop drinking on page 8 of the “a Step to a Healthier Baby” workbook, the client is referred to local behavioral health providers in their community utilizing Form J, Referral Form.

The regular service delivery system of Health Start requires local delivery sites to provide at least one face to face, home visit to enrolled prenatal clients per month. If it is convenient for the client to meet at another location, such as the office of the local delivery site, that option is provided. No phone call visits are allowed since one of the key benefits of the program is to be aware of the changing needs of the at-risk client and develop a close relationship providing advocacy and support during the client’s pregnancy. It is also important to conduct an assessment of their needs including safety issues in the home and observe the social dynamics of other members of the family. The SBI intervention services and follow-up visits have been integrated into the regular required monthly visiting of all prenatal clients. However, during OY3, sites were given permission to conduct FASD follow-up visits to fill out Form D via phone call if that worked better with their schedule and that of the clients.

The system that is utilized to track those women who are in need of monthly follow-up visits is to provide each local delivery site a list of clients who screened positive and who are required to have a Form D filled out each month until the birth of the child. This information is provided within 30 days of the previous month after all data from that month is entered into the data base. The list of clients is also discussed at the FASD Subcommittee Team meeting every month. If a client, who had initially scored eligible for alcohol use at enrollment, states at follow-up using Form D, that she has had alcohol in the past 30 days, the Community Health Worker will provide the Form C, TWEAK form again and go through the “A Step to a Healthier Baby” workbook. All family follow-up visits must be provided in person and must be at a minimum, 30 minutes in length and include a health education topic.

The process the Health Start Program utilizes to share the client's maternal alcohol history with the child's physician is predicated on the women's agreement to having the record sent in the first place. The Intent to Participate form was revised in 2008 to include a statement that the client agrees that information given to the Community Health Worker may be shared with the child's health care provider. Each of the local delivery sites has a HIPAA form that allows her record to be shared with the child's pediatrician or physician. However, the language on the required SAMHSA Center for Excellence Form E – Process Information Form states “Did the client agree to allow her record to be shared with the child's pediatrician or physician?” The SAMHSA Center For Excellence Form G – Follow-up after the Child Was Born also includes the question “Was the client's record, including whether she drank during pregnancy, sent to the child's pediatrician or physician?” These are two instances where the Community Health Worker, in most cases has verbally restated the option again and literally asks the client who scored eligible about agreeing to send the information. During OY3, it appears that most of the clients in Health Start are not verbally agreeing to have their information sent when actively asked this question by the Community Health Worker after the baby is born. If a client is in agreement, a letter on the local delivery site letterhead is sent out to the child's provider within two months after delivery that states “This letter is to inform you that the mother of _____ (one of your patients) screened positive for alcohol use during pregnancy while participating in the Health Start Program Fetal Alcohol Spectrum Disorders Screening and Brief Intervention Project. A copy of the screening tool is attached for your information. The client has agreed to share this information with you. If you would like further information, please contact: _____.” As each client that scored positive delivers her baby and is in agreement to have her information shared, the local site prepares the letter and attaches her screening form to the letter and sends it to the child's physician. This works well in the three community health care centers where the client and her child is also receiving medical care after the delivery.

c. Staff Training

The thirteen local delivery sites participated in a FASD Screening and Brief Intervention training on June 8, 2011. There were 25 participants attending the day long training. The training provided an overview of fetal alcohol spectrum disorders, strategies for prevention and the screening and brief intervention project tools. The steps of the screening process were covered utilizing the Form C – First Visit Screening Questions with TWEAK. A flow chart was reviewed with the participants along with all the other required forms that needed to be filled out if the client screened positive. Instructors from Northrop Grumman did several activities with the participants including an exercise on drink sizes and client motivation. In addition, modeling on the proper techniques for the brief intervention process and going through the “A Step to a Healthier Baby” workbook was provided. The need for the training was prompted by the addition of the five new sites that started in August 2010. The data results from the eight sites also indicated a need to go over again the need to provide the brief intervention education right away after a client screened positive. There had been many new staff added by the thirteen sites due to expansion and staff turnover during the year.

A second training was held on motivational interviewing on April 7, 2011 at Arizona State University due to the continuing need to have Community Health Workers develop the skills to move clients more quickly into behavior change and to have the client more readily agree to participate in the SBI project. There were 40 attendees at the Motivational Interviewing training which provided excellent information and techniques to work with resistant clients. The Northrop Grumman sponsored SBI training was held June 15, 2010 in Phoenix. All the Health Start sites were invited to attend the training which was provided by the California WIC subcontractor. This training was well attended by over 25 Community Health Workers and coordinators from 13 sites. One of the key elements of the training was the hands on practice of providing a brief intervention education session. This was good practice for those out in the field providing the screening and brief intervention. One of the biggest gaps in the training is a thorough review of all the forms especially Form C – First Visit Screening Questions with TWEAK and all the possibilities that can occur, including the client not agreeing to participate.

The Arizona FASD SBI project has developed a centralized data entry process whereby the yellow copy of the two part Form C's and all the other forms are sent into the ADHS by the 10th of each month either electronically, faxed or through regular mail. The data is reviewed and entered for each site for the monthly report. If there are any missing data or forms, the site is e-mailed immediately and instructed to provide the necessary information or required form. The Data Quality Manager for the Arizona FASD SBI project provided data analysis and monthly follow-up status reports on an ongoing basis to the local delivery sites for all of OY3. This helped the local sites provide the necessary forms and conduct follow-ups in a timely manner. The Project Director provided onsite technical assistance to the local sites to answer any questions and to provide the updated revised forms. The epidemiologist position remained open during OY3 and recruitment continued until a suitable candidate was found. The position was filled by the end of June 2011. The updated training provided by Northrop Grumman on the revised database for data entry and reporting in 2011 satisfied the needs of the Arizona FASD SBI project. The availability of the HSRI consultant has actually been more helpful as individual problems and issues arise. The sending of the data base during OY3 for revisions and the changes that resulted have been beneficial overall.

d. Task Force and Stakeholders

The Arizona Task Force on Preventing Prenatal Exposures to Alcohol and Other Drugs was created in 2005 by the former Democratic Governor Janet Napolitano, who left the office in 2009 to become the Secretary of Homeland Security. The Task Force is co-chaired by a Democratic State Senator, Linda Lopez from Tucson and a medical professional, Cynthia Beckett from Flagstaff who is also a designated FASD State Coordinator. The Arizona Task Force is comprised of approximately 20 appointed members who represent state, private and community agencies and parents that are actively involved in disease prevention and health promotion activities for women and children. The Task Force has the ability to access the administrative structure of the ARC of Arizona, a 501c3 organization for limited clerical and financial operations. The Arizona Task Force functions in an advisory capacity for the Arizona FASD SBI project, providing overall input and guidance only on an as needed basis. Updates on the project activities are provided to the Task Force monthly or as meetings are held. No Statewide Task Force meetings regarding FASD project activities around the state were held in OY3. A smaller FASD Subcommittee Team component of the larger Task Force was developed that addresses the specific needs of the project. The medical professional co-chair of the Arizona Task Force also sits on the Subcommittee Team when she is available, to provide training, guidance and support. The stakeholders on the Subcommittee Team are Health Start Program local delivery sites providing the SBI project. Most all of the Team members have over ten years experience working with the ADHS in some capacity as a subcontractor.

The Subcommittee Team provides monthly input during the monthly FASD Subcommittee conference calls. Each month, coordinators and Community Health Workers from the thirteen sites participate on the call and contribute to the information discussed. A review of the previous month's data is provided and those that have gaps are identified. A reinforcement of screening and brief intervention procedures is reviewed every month. Participants are given an opportunity to raise any client screening issues or other client issues during the conference call. The members have influenced the need to not let the clients fill out the final eligibility questions on Form C and to transition right into the BI of a client screened eligible. Many sites are providing the education using the booklet to all clients after the screening; however, they are only filling out a Form E – process form for those who screened eligible. Further training on motivational interviewing and on FASD in general has been an outcome of the monthly Subcommittee Team meetings as well as ongoing training on the effects of alcohol and other drugs of the developing fetus and the consequences on the child. The Subcommittee Team is also sharing power points they developed specific for their populations and Spanish materials with each other. They also shared information on the FASD Awareness Day activities including a Pregnancy Pause Kit that was developed by the Task Force Co-Chair.

The Arizona Task Force has strengthened the collaboration between state agencies in FASD prevention and treatment. The Arizona Department of Behavioral Health Services prevention and treatment divisions have provided information and resources to ADHS to distribute to the Subcommittee Team. The ADHS FASD SBI project has provided data on service outcomes to the Arizona Task Force yearly and has participated in any monthly

meetings that are held. Currently, the Arizona Task Force is working on an initiative to increase the sales tax on alcoholic beverages called Pennies for Prevention – A Dime a Drink, in an effort to present to voters in the next year or two, an opportunity to fund prevention and treatment programs in Arizona.

The Arizona Task Force has provided ongoing support to the Subcommittee Team in the integration of the SBI and has encouraged working with families impacted by FASD. As a result, the local delivery sites are more aware of looking for the trend of FASD being in a family and referring mothers and other children to screening services.

e. Lessons Learned

The Arizona FASD SBI Project has provided many learning opportunities during the integration into the Health Start Program during OY3. The addition of five new sites for a total of thirteen sites presented a challenge in terms of volume of forms received. This has required that the centralized data entry be organized and provided by the Project Director, Data Manager and Data Specialist in OY3 and continuing through OY4. It has also been very apparent that the topic of alcohol use among the pregnant women and their families in the Health Start Program is a sensitive issue which previously, was not being assessed or discussed in any depth prior to the integration of the project. It was originally estimated in the proposal that as many as 50% of the Health Start clients would screen positive for alcohol use during pregnancy. After two full years of implementation, it is closer to 20%, which is now lower than the 23% that was presented in the O’Conner and Whaley study of WIC participants. This decrease from 25% to 20% may partly be due to the increase in the predominately Hispanic population that is served by Health Start being screened in the border communities. Historically, the pregnant women that are first generation immigrants to Arizona retain their healthy habits and values and therefore are not disclosing alcohol use during pregnancy. It has also become clear that the participating sites and their staff tend to interpret the delivery process and screening questions very literally and may not understand the purpose of the follow-ups at 36 weeks and the need to inform the child’s physician after the birth. Community Health Workers indicated that they were less hesitant to not provide the education in OY3 due to the client stating that they did not drink once they found out they were pregnant. Most sites, after continuous training by ADHS and monthly reminders, finally understood the benefits of providing the education to all clients who were eligible and at risk and did not provided as much of an opportunity for the client to not participate. Clients who signed the Health Start Program Intent to Participate consent form did initially consent to participate in the SBI Project. Clarification was provided to the Community Health Workers and they went forward with providing the education. Continued monthly reminders with tables of clients that need the brief intervention Form E or monthly Form D’s continues to be absolutely necessary in order to have the sites conduct the project with fidelity. The main lessons learned by the Subcommittee Team are that the screening tool is too long and not always easy for clients and Community Health Workers to understand. Many Community Health Workers requested that the screening tool be shortened since clients seemed to appear overwhelmed at the length of the questions. Training on the screening process and the use of each form and the timely return of completed forms needs to be ongoing during the integration. The revision of the Arizona specific flow chart for the project was an accomplishment as well as the directive that all clients and their families need to receive the education on FASD as part of their regular FASD visit regardless of whether they scored eligible or not. The Project conducted a second motivational interviewing training during OY3 which reinforced the techniques necessary to move eligible clients toward behavior change to stop or reduce drinking. The centralized data collection and data entry is an important accomplishment which will be continued throughout the rest of the project in OY4. Consistent monthly follow up with sites is a strategy that was started during OY2, which was continued during OY3, will be repeated again in OY4. Data reports on a timely basis offer needed feedback to sites and show their gaps on a regular basis. The most significant accomplishment during OY3 included the implementation and complete integration of the FASD SBI Project into the new program contracts for the next 5 years and fully integrating the screening and brief intervention into the Health Start Program Price Sheet as a reimbursable service for every funded site. The FASD SBI Project was added as a requirement under the Policy and Procedures for the Health Start Program in OY3 in the revised manual. Sharing information with the public behavioral health system and participating in the Women’s Treatment

Provider meetings was an important link to the referral process that is integral to the project continuum of care for women and their families. The internal ADHS FASD workgroup that also includes the University of Arizona Medical School staff met several times via conference calls in OY3 to share information on various funded projects and offer support. The continuation of the Subcommittee Team of the State Task Force on Alcohol and Other Drugs provided a mechanism that was more closely tied to the FASD SBI initiative and provided for sharing of information and data in an effort to improve the implementation process.

4. Program Changes

a. Integration of Evidence-Based Interventions in the State Program or Local Delivery Organization.

The Arizona FASD SBI initiative has been integrated into the currently existing Health Start Program at thirteen local service delivery sites during OY3. A summary of changes is provided in Table 1 – Summary of Project Changes OY3. The program serves pregnant women at risk for poor birth outcomes and their families, providing education advocacy and linkages to medical and social services in their communities. Home, clinic or other location visits are provided to enrolled pregnant women by Community Health Worker staff at the sites. The FASD SBI initiative will be integrated at any new funded projects under a new Request for Proposal to expand the program in OY4. The integration of evidence-based strategies within the Health Start Program service delivery system will decrease the incidence of FASD by assisting pregnant women to achieve abstinence from alcohol. All pregnant women enrolled in the Health Start Program sites will be screened for current alcohol use utilizing the modified TWEAK, a three page screening tool in English and Spanish. Those enrolled clients screening positive will receive the brief intervention education.

The FASD initiative has fit well within the Arizona Health Start Program with minimal changes. The integration of the FASD Initiative into the Health Start Policies and Procedures is compatible with the mission and goals of the program. The FASD Initiative was selected by the BWCH Health Start Program due to the complementary goals of improving the health status of women, infants, and children by eliminating the prevalence of alcohol use and dependence among pregnant women.

The Health Start sites are required by contract to adhere to the policy and procedures as set forth by the ADHS.

The following language was added to effected sections of the revised policy and procedure manual in OY3:

Chapter 7 – Client Visits and Prescheduled Classes

7.2 Prenatal Visits and Classes (insert)

When to Provide the Alcohol Screening Questionnaire/Referrals for Screening & Screening Process

At the enrollment of the new client, the revised Form C Alcohol Brief Intervention First Visit Screening Questions with TWEAK Screening Questionnaire (developed by Northrop Grumman and provided by the ADHS) will be given to the client by the Community Health Worker. Referrals from other agencies or programs may be accepted if the potential client meets the enrollment criteria for the program. Client will be instructed to fill out the questionnaire or the Community Health Worker will ask the questions and fill it out for the client. The Questionnaire is available in English and Spanish. The Questionnaire is scored by the Community Health Worker. The scoring guide on the questionnaire is filled out by the Community Health Worker. Women, who answer one or more to question six or score two more points on the TWEAK questions, are eligible to be provided Brief Intervention education during the enrollment/first prenatal visit. Integrating the screening into the enrollment and first prenatal visit has lengthened the first visit by at least thirty minutes for a total of one hour. This has caused some local

delivery sites to adjust their scheduling process of enrolling new clients and providing the first prenatal visit. The source of referrals is WIC, outpatient prenatal clinics, or the prenatal clients hearing about the program from friends or family. Community Health Workers have had to adjust their recruitment efforts as well, to work more collaboratively with staff in those programs in order to receive referrals and to actively recruit and conduct more outreach to at-risk women. A copy of the Form C in English or Spanish is provided to ADHS by the 10th of each month for every client screened. Forms may be, faxed or scanned by the sites in order for them to be received by the 10th of each month.

Brief Intervention Process

The Community Health Worker will use the “A Step to a Healthier Baby” workbook, provided by ADHS (English and Spanish) to conduct the Brief Intervention. A copy of the Alcohol Screening Questionnaire will be kept in the client’s medical file and the original will be provided to the ADHS by the 10th of each month and submitted with the monthly billing. The Community Health Worker will fill out the Form E Process Information questions provided by the ADHS after each Brief Intervention and will put a copy in the client’s medical file and provide the original to ADHS with the monthly billing. This change of the submittal date of the monthly billing has caused some change within each site because they must process their billing invoices earlier. There are sites that are consistently late with submitting their FASD forms due to their own bureaucracy; however, most are sending the forms in on time. In those cases, faxed or scanned forms are accepted by the 10th of each month.

Follow-up Process

At the next monthly prenatal visit, the Community Health Worker will ask one question regarding alcohol use if the client screened negative or if the client screened positive and received the Brief Intervention, they will ask four follow-up questions provided by the ADHS and fill out Form D Alcohol Brief Intervention Follow Up Visit Questions only at the 36th week follow-up visit. The questions were integrated on the Health Start Prenatal Visit Form in the FASD Screening and Intervention block during OY1 but they were taken out during OY2 once Northrop Grumman provided the revised screening form and supplemental forms for the initiative including a Form D Follow-Up Visit Questions. There have been barriers to completing the 36th week follow-up by the local delivery sites which have been identified. The Community Health Workers have had difficulty tracking some of the clients that scored positive due to the frequent change in contact information by the transient nature of the population. Many are not available for a home visit during the 36th week time period or have dropped out of the voluntary program. The ADHS FASD SBI project began providing monthly conference calls and e-mail reminders as well as tables of clients to the local delivery sites with lists of clients that are due for a 36th week follow-up visit and requesting that the sites conduct the visit as soon as possible and fax or scan the form in to the Program. Home visit scheduling issues have consistently been a barrier to complete this in a timely manner in order for the data to be received, entered and counted. Due to the reimbursement mechanism set up by the Program whereby each local delivery site is reimbursed for a home visit based on a set unit rate, phone call visit are not allowable and would not be counted as a face to face visit. This presents a considerable challenge of time and effort by the local delivery sites.

Referrals to More Intensive Treatment

Referrals for more intensive alcohol treatment will be made by the Community Health Worker if the client indicated that they drank four or more drinks on any one occasion, scored four or higher on the TWEAK, and/or they reported a low level of confidence in stopping drinking (page 8 of the “A Step to a Healthier Baby” workbook). Referrals will be made to internal and external providers and will be tracked by the Community Health Worker to determine if the client received treatment. Copies of the referral form and documentation of the referral will be recorded on the provided forms, and sent to the ADHS in the monthly billing. Originals will be sent to the referral agency and kept in the client chart. Community Health Worker will complete the FASD Referral Follow-up Questions on the Prenatal Visit Form.

The Arizona FASD SBI initiative has finally utilized the Referral Form J during OY3 and four formal referrals were made to clients. Clients that were in need of further services were referred to regular outpatient or intensive inpatient treatment for services. Many more were also referred to be evaluated but may have already been receiving services through outside agencies or refused to accept a referral and were therefore not captured on Form J. There was a tremendous effort by ADHS to emphasize the importance of following the client all the way through to monitor the referral; however, there was little feedback provided. This will also be emphasized in OY4. The local delivery sites were provided a list of behavioral health treatment services contacts in their communities by ADHS and were encouraged to develop a relationship with those providers.

Brief Intervention Sessions and Follow-up Visits

The Community Health Worker will provide the Brief Intervention at additional times to the client if a client continues to drink. If a previously negative client indicates that they are drinking at any time during the pregnancy, the Alcohol Screening Questionnaire will be given again and a Brief Intervention provided if indicated. The Community Health Worker will provide another Brief Intervention at 36 weeks to all pregnant clients who scored positive and received a Brief Intervention during the first prenatal visit only if the client continued to drink during pregnancy. The Form D will be filled out at the 36 week follow up home visit by the Community Health Worker. This has been difficult for the Community Health Workers to implement and fill out the required forms. Many clients are lost to follow-up due to moving out of the area or dropping out of the program. Many clients are hard to contact and change phone numbers and residences making it difficult for Community Health Workers to contact them to arrange for monthly visits.

Administration of Follow up Assessments

The local delivery sites will be provided a table of positive clients that are in need of a brief intervention if they were not provided one or the Form E was not turned in. In addition, ADHS will provide a table of those clients needing the 36th week follow-up and those that are in need of the postpartum follow-up by the 15th of the following month. Local delivery sites have implemented a tickler file system within their own programs to identify those clients that need visits at 36 weeks and need to have Form D filled out. The challenge is mainly due to client availability and the completion of the Form D in time for it to be entered into the database as well as the completion of Form G or Form H at the end of program.

Family Follow-up after the Birth

The Community Health Worker will visit the mom within two weeks after the birth of the baby. If the mother had screened positive for alcohol use during pregnancy, the client's record which in this case will be the Form C – First Visit Screening Questions with TWEAK form, needs to be copied and sent to the baby's health care provider. The FASD follow-up questions after birth on the Family Follow-up Form need to be completed. The Ages and Stages Assessments need to be conducted at the monthly intervals as required and any developmental delays need to be documented in the chart.

The barrier to sending the record to the health care provider has been the client refusing postpartum to have the record sent. Many have second thoughts about agreeing to have any information shared and decide against it. The local delivery sites have been trained in OY3 to provide the letter to the provider if that information is available and if the client has signed the Consent to Participate form for the program which includes the permission. Clients may have second thoughts about the decision either way and are not pressured to have the record sent to the provider.

There have not been any changes to State or local policies or programs outside of the Arizona Health Start Program within the Arizona Department of Health Services (ADHS), Bureau of Women’s and Children’s Health. There has been an increased effort to collaborate with the ADHS Division of Behavioral Health Services and their programs that provide treatment services in the communities served and to collaborate with other related funded programs with the ADHS. A comprehensive list of treatment services specific to women and pregnant women was provided and distributed to the local delivery sites. There have been several efforts to raise awareness of the need for screening among other ADHS program that have contact with pregnant teens and women such as WIC and teen pregnancy prevention programs. However, these programs have yet to implement any in depth screening for alcohol use due to priority setting. There has been an establishment of an internal ADHS work group which is working with the University of Arizona on the CDC FAS surveillance project and the ADHS birth defects surveillance project. This effort has combined the systems of prevention, screening and brief intervention and diagnosis and treatment of infants and children who may have FASD that will share data and resources.

The state funding for the Arizona Health Start Program has remained stable the last three years of the Program. The source of state funds is the state lottery which has maintained or even increased its level of revenue during the dire economic crisis occurring in Arizona. The FASD SBI initiative was integrated easily into the data management and other internal procedures with the ADHS Bureau of Women’s and Children’s Health. The Assessment and Evaluation Unit created a half-time epidemiologist position which under the SBI Initiative has provided some data support and analysis for reports and for the FASD poster presentation. That position was only held by staff for only 10 months, but was filled at the end of June 2011. Data entry, analysis and assessment will be transferred to the Data Manager and the Epidemiologist who will be trained on data entry and quality assurance during OY4. During OY3 there was a need to provide monthly lists of clients that need 36 week follow-ups and post partum follow-ups provided monthly to the local delivery sites. This will be continued by the Data Manager and Epidemiologist and will be checked on a more consistent basis to ensure that all needed forms have been turned in and entered as soon as possible into the FASD SBI data base.

Table 1 - Summary of Project Changes OY3

Change Category	Description of Change
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State/local policies and procedures	Arizona Revised Statute 8-2201(22) c revised to add to definition of neglect a "determination by a health professional that a newborn infant was exposed prenatally to a drug or substance listed in section 13-3401." (effective 2010)
Organizational policies and procedures	Health Start Policy and Procedure Manual revised to include required screening of all enrolled prenatal clients.
Systems integration (intake, screening, case coordination, internal and external system referrals, etc.)	SBI process integration written into new Health Start subcontracts for FY11 as a requirement. Additional referral resources identified and coordinator with Division of Behavioral Health Services systems and Women's Treatment providers throughout the state.
Service delivery processes (individual vs. group formats, new clinical techniques, case management, etc.)	SBI is incorporated as part of the regular client intake/enrollment process. Motivational interviewing skills applied to BI. Follow-ups and referrals managed more closely by Community Health Workers. Increased knowledge of need for SBI through training.
Data Systems (integration of program data, centralization, etc.)	SBI data is utilized to drive the need for increased referrals. Centralization of data entry and coordination by ADHS. Follow-ups and data cleanup activities managed by ADHS through local delivery sites.
Staffing (new training focuses, staffing structures, qualifications for new hires, etc.)	On-going training provided on basic etiology of FASD using FASD 101, Recovering Hope video, print materials from the FASD Center for Excellence and NOFAS. Increased concern and awareness of clients affected by an FASD and other family members. New staff required to attend FASD training.

APPENDIX I

SBI Annual Report: Arizona

Data Collection Activity 8/1/2010 and 7/31/2011

Demographic Data	All clients		Total Responses
	N	%	
3. Of the women who reported race, N/% Alaska Native*	1	0.1	996
4. Of the women who reported race, N/% American Indian*	144	14.5	996
5. Of the women who reported race, N/% Asian*	16	1.6	996
6. Of the women who reported race, N/% Black or African-American*	20	2	996
7. Of the women who reported race, N/% Native Hawaiian or Pacific Islander*	3	0.3	996
8. Of the women who reported race, N/% White*	813	81.6	996
9. Of the women who reported ethnicity, N/% Hispanic/Latina	648	65.1	996
10. Average age of women at screening	24 years	N/A	996
11. Of the women who reported educational status, N/% who completed GED/12th grade or higher	458	46	995
12. Of the women who reported educational status, N/% who completed less than GED/ 12th grade	368	37	995
13. Of the women who reported marital status, N/% who identified as “married”	315	31.7	994
14. Of the women who reported marital status, N/% who identified as “unmarried, living with partner”	302	30.4	994
15. Of the women who reported marital status, N/% who identified as “never married”	338	34	994
16. Of the women who reported marital status, N/% who identified as “widowed”	2	0.2	994
17. Of the women who reported marital status, N/% who identified as “divorced or separated”	37	3.7	994
Screening			
18. Of the women screened, N/% screened eligible for program	196	19.7	996
19. Of the women who screened eligible, N/% who agreed to participate in program	173	88.3	196

*Because respondents can select more than one race response, the total percentages of Q3-Q8 may not sum to 100%.

SBI Annual Report: Arizona

Data Collection Activity

8/1/2010 and 7/31/2011

	Qualified based on screener score only ("baseline non-drinker")			Qualified based on past-30-day alcohol use ("baseline drinker")				
	N	%	Total Responses	N	%	Total Responses		
Baseline Characteristics								
20. Of the women who screened positive, median number of days women drank alcohol in the past 30 days at screening	0	days	N/A	153	1	days	N/A	43
21. Of the women who screened positive, median number of drinks (from "0" to "10 or more") consumed on a typical day when drinking alcohol in the past 30 days at screening	0	drinks	N/A	153	2	drinks	N/A	43
22. Of the women screened positive, N/% of women who had 4 or more drinks in 1 day in the past 30 days at screening	2		1.3	153	29		67.4	43
23. Of the women screened positive, N/% given 1 or more referrals to treatment for additional assistance to stop drinking alcohol	4		2.6	153	4		9.3	43
Intervention Services								
24. Of the eligible women who agreed to participate, N/% participated in at least one intervention session	121		89.6	135	29		76.3	38
Program Completion								
25. Of the eligible women who participated in at least one intervention session and are due for the third trimester follow-up, N/% completed the intervention, as evidenced by a follow-up form completed in the third trimester	71		74	96	12		66.7	18
Alcohol Use Outcomes								
All clients								
26. Of the eligible women who reported drinking alcohol on at least 1 day in the past 30 days at screening, participated in at least 1 BI session, and completed the follow-up visit form in the third trimester, N/% of women who decreased frequency of alcohol use in the past 30 days at program exit	11		91.7	12				
27. Of the eligible women who reported drinking 1 or more drinks on a typical day when drinking alcohol in the past 30 days at screening, participated in at least 1 BI session, and completed the follow-up visit form in the third trimester, N/% of women who decreased the number of drinks consumed on a typical day in the past 30 days at program exit	11		100	11				
28. Of the eligible women who reported having 4 or more drinks in 1 day in the past 30 days at screening, participated in at least 1 BI session, and completed the follow-up visit form in the third trimester, N/% who decreased the number of days drank 4 or more drinks in the past 30 days at program exit	7		87.5	8				

SBI Annual Report: arizona

Data Collection Activity 8/1/2010 and 7/31/2011

	Qualified based on screener score only ("baseline non-drinker")			Qualified based on past-30-day alcohol use ("baseline drinker")		
Alcohol Use Outcomes continued	N	%	Total Responses	N	%	Total Responses
29. Of the eligible women who participated in at least 1 BI session and completed the follow-up visit form in the third trimester, N/% who reported no alcohol use in the past 30 days at program exit <i>(Women reporting abstinence at program exit)</i>	72	100	72	11	91.7	12
				Qualified based on past-30-day alcohol use ("baseline drinker")		
			Total Responses			
			N	%	%	Total Responses
Service Dosage for Clients who Qualified Based on Past-30-Day Alcohol Use 30. Of the eligible women who participated in at least 1 BI session and completed the follow-up visit form in the third trimester, N/% who reported at program exit that they had not drunk any alcohol since the first session when they talked about drinking <i>(Women reporting abstinence after 1 session)</i>	11	91.7	12			
31. Of the eligible women who participated in at least 1 BI session and completed the follow-up visit form in the third trimester, N/% who reported no alcohol use in the past 30 days on all follow-up forms after the second completed process form <i>(Women reporting abstinence after 2 sessions)</i>	0	N/A	0			
32. Of the eligible women who participated in at least 1 BI session and completed the follow-up visit form in the third trimester, N/% who reported no alcohol use in the past 30 days on all follow-up forms after the third completed process form <i>(Women reporting abstinence after 3 sessions)</i>	0	N/A	0			
33. Of the eligible women who participated in at least 1 BI session and completed the follow-up visit form in the third trimester, N/% who reported no alcohol use in the past 30 days on all follow-up forms after the fourth completed process form <i>(Women reporting abstinence after 4 sessions)</i>	0	N/A	0			

SBI Annual Report: arizona

Data Collection Activity 8/1/2010 and 7/31/2011

	All clients		Total Responses
Post-Partum Follow-up	N	%	
34. Of the eligible women who participated in at least 1 BI session and completed the follow-up visit form in the third trimester, N/% who agreed to have their record shared with the target child's physician	78	94	83
35. Of the eligible women who participated in at least 1 BI session, completed the follow-up visit form in the third trimester, and agreed to have their record shared with the target child's physician, N/% whose medical records were sent to target child's physician	16	20.5	78

Interim Outcomes for Non-Program Completers

	All clients		
36. Of the eligible women who qualified based on screener score only ("baseline non-drinkers"), N/% who maintained abstinence from alcohol in the past 30 days at the most recent follow-up	31	100	31
37. Of the eligible women who qualified based on past-30-day alcohol use ("baseline drinkers"), N/% who reported abstinence from alcohol in the past 30 days at the most recent follow-up	7	100	7
38. Of the eligible women who qualified based on past-30-day alcohol use ("baseline drinkers"), N/% who reported decreased frequency of alcohol use in the past 30 days at the most recent follow-up	7	100	7