

Annual Report for Screening and Brief Intervention Subcontractors-

Great Plains Tribal Chairmen's Health Board

Data Collection Activity: August 1, 2010, through July 31, 2011

1. Project Summary

The goal of this initiative is to obtain agreement to abstain from alcohol use from pregnant American Indian (AI) women in Northern Plains American Indian (NPAI) communities within 13 Aberdeen Area reservations. The evidence-based Screening and Brief Intervention is integrated into the existing Northern Plains Healthy Start (NPHS) program, which provides health and targeted case management to pregnant and post-partum women. As a part of the Great Plains Tribal Chairmen's Health Board (GPTCHB), the NPHS mission is to address infant mortality and reduce health disparities of American Indian women and young children among its target population. The FASD Prevention Project supports the agency goal of improved pregnancy outcomes. The prevalence of alcohol use and abuse in the Native American culture presents a challenge that the NPHS prenatal clients have themselves identified. The need for loving support and encouragement from their families and friends not to drink while they are pregnant is paramount; within the existing culture, however, such support may not be readily available. Availability of referral sites for alcohol abuse and treatment for adolescents is particularly limited on the reservations.

This initiative provides several different process objectives for the population. Case Managers screen pregnant clients for alcohol use during the intake process for Healthy Start in order to serve 90% of women who receive Healthy Start services. If screened positive, the Case Manager will provide the Brief Intervention at intake to serve 85% of women who screen positive for alcohol use. They will then provide referrals for formal alcohol treatment to 100% of women who report more than occasional use of alcohol on the initial screening or who continue to use alcohol regularly on follow-up assessments. The Program Coordinator, Data Coordinator, Program Evaluator, and Northrop Grumman staff make policy to discontinue providing the Brief Intervention for clients who purposely seek a negative result on the alcohol screening (i.e. do not report their alcohol use on screening). They also develop procedures for follow-up outreach to these women.

Process objectives also exist for sustaining and enhancing the initiative and service delivery system. The Project Coordinator convenes the Task Force to continue to monitor program process and brainstorm ideas for program and system improvement. The Coordinator also provides S&BI refresher courses during site visits which take place at least twice a year. With the help of the Data Coordinator data is collected on 100% of clients screened. Sustainability for the projects future is always kept in mind. The current plan for future sustainability is the recruitment of different types of counselors to establish a third party billing system which will generate revenue to keep sites functioning and ensure that the S&BI continues in the Healthy Start system.

The project is designed to meet certain projected results. These results include 65% of NPHS pregnant clients who screen positive for alcohol use and receiving the Brief Intervention agreeing to abstain from alcohol use. 30% of these women would abstain from using alcohol within one month of receiving the Screening and Brief Intervention. The last result focused on is that 50% of NPHS pregnant clients receiving the Screening and Brief Intervention abstain from alcohol use by the beginning of the 6th month of pregnancy. The target audience for this initiative is all pregnant women who present to enroll in Healthy Start. . Enrollment in Healthy Start is available to all women who are pregnant or parenting and have one or more health or social risk factors; there are no income criteria. Incorporating the

Screening and Brief Intervention into the NPHS intake session takes place easily. New policies and procedures for integrating brief interventions into NPHS program continue to be planned and developed. Set up and management of the database has been furnished with help from Northrop Grumman advisors. The charge to the Task Force is to assist in planning, implementing and evaluating the integration and sustainability of alcohol screening, brief intervention, and referrals to treatment within the Northern Plains Healthy Start (NPHS) programs serving the Northern Plains American Indian communities. The Task Force also assists with the development of policies and procedures to implement the preventive intervention. Each site is a different community. The successes and challenges, however, are relatively similar. If one site is experiencing a phenomenon, the rest of the sites may have something similar happen in their work, although they may describe it differently. While some sites experience challenges in meeting their targets due to staff turnover or in having sufficient referral resources for their clients, these are the commonly understood challenges of reservations that cover wide areas and have limited medical care services and low-paying, high stress jobs that are typical of most reservations. It is important to understand that challenges and problems may not be systemic, but cultural, and is addressed as such. For example, the importance of word of mouth and reputation have a deeper and more powerful impact than most mainstream advertisement, marketing, and outreach. In looking at this initiative, it is focused on a truly unique population and culture; sites despite their differences have more similarities than differences. An understanding of these issues must be at the forefront of services and program analysis.

The program has been very accepted among people in the communities as well as with staff providing the S&BI. Staff have been very receptive to the program due to the lack of alcohol related services. Some of the different communities served have little to no services, or the closest place a client could be seen is 100 miles away. Healthy Start staff have a very good reputation in each of the communities they work and live in. Trust is already established so clients are willing to discuss their use or lack of use. The S&BI is instrumental for providing services for alcohol use where it is literally the only service available.

2. Key Client Results Achieved between: August 1, 2010, through July 31, 2011.

A. Target Population

The number of women in the target population eligible for alcohol use screening was 375 a year. The number of women screened for alcohol use was 400 a year which were 87% of the women in the target population eligible for screening.

B. Demographic Data

Of the women who reported race out of 267 responses: 1 (0.4%) was Alaska Native , 262 (98.1%) were American Indian, 1 (0.4%) was Asian, 2 (0.7%) were African American, 6 (2.2%) were Caucasian, no clients reported being Native Hawaiian or Pacific Islander. 8 (3.1%) clients reported being of Hispanic or Latin descent. This is not unusual as the project is held on American Indian reservations only. The average age of women screened was 24 years of age. These women reported that out of 266 responses that 110 (41.4%) had a GED, completed 12th grade, or had higher education where 131 (49.2%) had completed less than 12th grade. 267 clients responded that 27 (10.1%) were married, 114 (42.7%) were unmarried but living with a partner, 114 (42.7%) were never married, 10 (3.7%) were divorced or separated, and 2 (0.7%) had been widowed. This demographic data would identify the average client as being a 24 year old American Indian with less than a 12th grade education who is unmarried.

C. Screening

Of the 275 women screened, 116 (42.2%) were eligible for the Brief Intervention and 60 (51.7%) of those clients who were eligible for the Brief Intervention agreed to participate in the program. The low participation is partially due to a miscommunication between new program coordinators and the FASD contractor that led to FASD being treated as a separate entity rather than a Healthy Start service. This has been rectified.

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

Women that qualified based on screener score only:

Of the women who screened positive, the median number of day's women drank alcohol in the past 30 days at screening was 0 of 103 responses. Of the women who screened positive, the 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 was 0 of 103 responses. Of the women who screened positive who had 4 or more drinks in 1 day in the past 30 days at screening was 0. Of the women screened positive 1 was referred to treatment for additional assistance to stop drinking alcohol.

Women that qualified based on past 30 day alcohol use:

Of the women who screened positive, the median number of day's women drank alcohol in the past 30 days at screening was 2 out of 13 responses. Of the women who screened positive, the 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 was 4 out of 13 responses. Of the women who screened positive who had 4 or more drinks in 1 day in the past 30 days at screening were 12 out of 14 responses. Of the women screened positive 1 was referred to treatment for additional assistance to stop drinking alcohol.

There are many factors which can contribute to the lack of referrals. Many sites are so remote that there are no services close enough for the client to realistically attend. Many clients are already enrolled in services at intake. There is also a lack of services for younger clients.

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

36 clients out of 52 (69.2%) who qualified for the Brief Intervention based on the screen score only participated in at least one intervention session. 7 out of 8 (87.5%) who qualified for the intervention based on past 30 day alcohol use also participated in at least one intervention session. Of the eligible women who participated in at least one intervention session, 9 out of 25 clients (36%) who qualified based on the screen score only, completed intervention as evidenced by a complete follow-up form in the third trimester. Of the eligible women who participated in at least one intervention session, 1 out of 2 clients (50%) who qualified based on past 30 day alcohol use, completed intervention as evidenced by a complete follow-up form in the third trimester.

The success of FASD follow-ups is continuing to improve through new tools that were provided in the redesigned database that was received earlier in the year, reeducation of staff in FASD procedures, and the increased use of Client Tracking forms.

F. Alcohol Use Outcomes

1 out of 1 (100%) of the women who reported drinking alcohol on at least one day in the past 30 days at screening, participated in at least one Brief Intervention session, and completed the follow-up visit form in the third trimester, decreased alcohol use in the past 30 days at program exit.

1 out of 1 (100%) of the 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 one Brief Intervention session, and completed the follow-up visit form in the third trimester, decreased the number of drinks consumed on a typical day in the past 30 days at program exit.

1 out of 1 (100%) of the women who reported having 4 or more drinks in 1 day in the past 30 days at screening, participated in at least one Brief Intervention session, and completed the follow-up visit form in the third trimester, decreased the number of days drank 4 or more drinks in the past 30 days at program exit.

Of the eligible women who qualified based on screener score, participated in at least 1 Brief Intervention session and completed a follow-up form in the third trimester, 9 out of 9 (100%) reported no alcohol use in the past 30 days at program exit.

Of the eligible women who qualified based on past 30 day alcohol use, participated in at least 1 Brief Intervention session and completed a follow-up form in the third trimester, 1 out of 1 (100%) 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

1 out of 1 (100%) women who qualified based on past 30 day alcohol use participated in at least one Brief Intervention session and completed the follow-up visit form in the third trimester, reported at program exit that they had not drank any alcohol since the first session when they talked about drinking.

H. Post Partum Follow-up

2 out of 10 (20%) women who participated in at least on Brief Intervention session and completed the follow-up visit form in the third trimester agreed to have their record shared with the target child's physician. Of those 2 records none were sent to the physician. The child's records not being sent to a physician is very common with Northern Plains Native American Indian communities. After the child is born the family will utilize the Indian Health Service (IHS). This system is set up in a way where the family will not usually see the same doctor more than once. For this reason clients will generally not send the child's records to any one individual.

G. Interim Outcomes for Non-Program Completers

Of eligible women that qualified based on screener score only, 19 out of 19 (100%) reported abstinence from alcohol in the past 30 days at the most recent follow-up.

Of eligible women that qualified based on past 30 day alcohol use, 6 out of 6 (100%) reported abstinence from alcohol in the past 30 days at most recent follow-up.

Of eligible women that qualified based on past 30 day alcohol use, 6 out of 6 (100%) reported decreased frequency of alcohol use in the past 30 days at the most recent follow-up.

3. Program Description and experiences

a. Population Needs Identified and Addressed

There were several needs identified for the population that was addressed in the last year. One of the most important needs identified was the occurrence of “late disclosures.” That is, clients do not disclose their alcohol use at the screening, but staff has anecdotal information, personal knowledge, or knowledge from someone else in the community that a particular client is drinking. Staff provides the brief intervention, and women later report that they benefited from the intervention, even if they did not disclose at first. The need was identified when staff were sending in numbers of clients who received the Brief Intervention which were higher than the number who had screened positive. Through the Technical Advisors with Northrop Grumman it was decided that it was against the fidelity of the S&BI program to continue providing the Brief Intervention without a positive screening. To ensure program fidelity the Brief Intervention is provided only to pregnant women who screen positive for alcohol use. Staff were trained in motivational interviewing and attended an all staff conference where the importance of the issue was discussed. This has ceased to be an issue for the program.

There was a need to look at each site’s alcohol use based on whether unique factors account for higher or lower use. Specifically, it was suggested by site staff that variations in socioeconomic status account for some of the differences. This need was identified by the coordinator for the Trenton Indian Service Area, who suggested that oil rigs in the area provide a higher income for clients than at other sites and may influence alcohol use during pregnancy. The Data Base has been adjusted so that numbers can be looked at per site. Since the need was identified screening numbers have increased for sites with a higher socioeconomic status showing that it may not be a factor in alcohol use. It will continue to be monitored as more data is collected.

Another need identified was the occurrence in some sites of clients refusing to participate in the program after receiving a positive screening. The need was identified when staff sent in numbers for clients who received a positive screening and did not receive the brief intervention and/or did not return for follow-up Healthy Start visits. The all staff training which refreshed their skills in conducting the brief intervention, focused on motivational interviewing, and addressed the importance of intervention when a problem is identified contributed to assuring that women who do screen positive are encouraged to participate in the program. This also is no longer a need.

b. Service Delivery Process

For the service delivery process women are referred to NPHS by community agencies involved with health care such as Indian Health Services (IHS). Each reservation is its own community and there are slight variations as to what services are provided at which site. NPHS is as popular and trusted program which has been around for over a decade. Many women are referred through word of mouth as soon as they become pregnant. NPHS enrollment forms are completed at the first formal encounter with the pregnant client. Each subsequent visit is tracked on encounter forms. Encounter forms document all educational topics covered, referrals made and any other service provided. The brief intervention has been added to the encounter form so that case managers can select that as an option for any encounter in which a brief intervention is conducted. Each different community has different referral sources if the woman needs further services with alcohol use. Many communities have no resources for women except the support of NPHS staff along with this initiative. FASD forms which are completed at the brief

intervention are attached to the form for that session and sent to Central Office. For the outcome evaluation, assessment of alcohol use at the beginning of the sixth month of pregnancy and before the client's due date for delivery is required for consistent assessment of alcohol cessation. At that time, the follow-up FASD forms are completed.

Outcomes with respect to the percentage of women screened and the percentage who receives brief interventions are directly documented on the enrolment and encounter forms. Outcomes with respect to the frequency and quantity of alcohol use are assessed at enrolment, monthly after the initial screening and brief intervention during the third trimester of pregnancy. Post-partum documents, collected immediately after delivery.

Usually records are not sent to a physician. The Native American Indian population that make up a majority of our clients are unique in that they receive health care from the United States government. IHS serves the mothers and the children after the child is born but the same doctor is rarely seen more than once. It is this reason that records are rarely sent because doctors rotate so often. Forms are sent to the Central Office twice a month by site staff. The data is then imputed into the Data Base. This is how follow up information is collected. Women due for follow up are usually seen as staff naturally see their clients on an at least monthly if not weekly basis. Recently women due for follow up are tracked by use of the Data Base and staff at sites are contacted by the Central Office and notified as to what clients are needed to be seen for follow up information.

c. Staff Training

The training of Staff with the Brief Intervention was very informative and adequate. There has not been any staff turnover at the different sites. These are the people who provide the Screening and Brief Intervention and have gotten very adept at providing the service. Videos were provided with examples of the intervention that staff found extremely valuable. The all staff training held focused more on the Screening and different ways of using motivational interviewing to get clients to disclose alcohol use. Although we have received ongoing technical assistance, the main need continue to be training on the Data Base.

d. Task Force and Stakeholders

The charge to the Task Force is to assist in planning, implementing and evaluating the integration and sustainability of alcohol screening, brief intervention, and referrals to treatment within NPHS. The Task Force assists with the development of policies and procedures to implement the preventive intervention. Task force members are chosen from the body of staff who work for or with the NPHS program. Each Task Force member is required to attend scheduled meetings, meet the project's goals, and complete assigned tasks in accordance with the project Work Plan. There is a Task Force member from each of the four states serviced by NPHS (South Dakota, North Dakota, Nebraska, and Iowa) plus the FASD/ NPHS Director and 3 Central Office Staff.

Meetings are co-facilitated by the FASD/NPHS Director. It is the Director's responsibility is to develop meeting agendas and to communicate meeting minutes to all Task Force members (in writing or by e-mail). The Director guides the Task Force in the integration of the Screening and Brief Intervention program according to the Statement of Work (SOW) and into the existing service delivery systems of NPHS. Task Force members representing participating states bring their expertise in cultural relevance and experience working with pregnant women who drink, and data collection and evaluation. All members have an equal voice, and are able to bring concerns to the attention of the Task Force members. All Task Force members are eligible to add issues to the meeting agendas as long as they

pertain to implementing the Screening and Brief Intervention as outlined in the SOW. The Task Force has discussed a great deal of what goes on with the initiative.

e. Lessons Learned

Several topics have been learning experiences. Staff report clients not drinking and being followed up on but numbers continue to be low on the Data Base and reports. This is an area that would need focused on more. It is beneficial to have staff available that has expertise in data bases in general. We also learned that continued training in motivational interviewing is beneficial to decrease the instances of “late disclosures.” This initiative is good to have due to lack of treatment resources in many of our rural communities. In some of our remote communities this initiative is all that is available for prenatal alcohol consumption. Sustainability is a topic that the Task Force continues to discuss. We also have learned that sending statistics to our sites for motivation is beneficial. This keeps them interested in the program. A great learning was that many clients who are “late disclosures” do so because of a fear of being punished by outside entities such as the Department of Social Services. Staff use this knowledge in gaining trust with their clients to disclose alcohol use for the benefit of their health and their child’s health rather than a means to get into trouble. This helps with trust and the initiative is seen as positive now because staff can work with the client through the Brief Intervention rather than simply referring the client elsewhere. This is an accomplishment because now treatment centers on some sites are so overwhelmed they refer to NPHS to provide the S&BI.

4. Program Changes

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

Change Category	Description of Change
State/local policies and procedures	Integration of the S&BI has changed policies and procedures within the NPHS program. Many of these changes were to be compliant with HIPPA rules and confidentiality.
Organizational policies and procedures	Previously the client identification number was the client’s social security number. According to HIPPA regulations this number could not be used as it did not protect the person’s confidentiality. This was changed to a random number formulation. This was directly due to the integration of the S&BI initiative and the creation of the Data Base. Releases of Information were also adopted specifically for NPHS because of the S&BI integration. It can be rare that charts and information is sent to a physician, but when it does happen there needed to be protocol in place for that to happen smoothly while protecting the client’s confidentiality. Informed consents were also made mandatory because of the S&BI integration. Sites were not all using them or using them correctly. Data collection has also been made a priority. Although data was collected in a timely fashion for the NPHS needs it needed to be refined and changed to turning in records bi-monthly.

<p>Systems integration (intake, screening, case coordination, internal and external system referrals, etc.)</p>	<p>Some aspects of the SBI program have changed as a result of the integration of this initiative into the NPHS program. Referrals for services to NPHS have increased in general due to the referrals for screening. Some treatment centers have been referring to NPHS for the S&BI. The screening has not changed dramatically but staff now provide the Brief Intervention based on the number of drinks the client reports having before feeling the effects of alcohol as two or more.. Some staff were not doing this as they did not know it was an indicator for risk of having an alcohol exposed pregnancy. . Staff were also instructed to no longer provide the Brief Intervention to clients who did not screen positive. Staff at some sites were providing the Brief Intervention to individuals they learned were drinking in the community but were purposely screening negative to avoid staff finding out. These clients are now being explained in a better way that the intent for the screening is to protect the health of the client and her child. Follow –up visits have not changed but are now being tracked more efficiently.</p>
<p>Service delivery processes (individual vs. group formats, new clinical techniques, case management, etc.)</p>	<p>The Native American Indian population that make up a majority of our clients are unique in that they receive health care from the United States government. IHS serves the mothers and the children after the child is born but the same doctor is rarely seen more than once. It is this reason that records are rarely sent because doctors rotate so often. This aspect of providing services will most likely not change although the Screening and Brief Intervention are a part of the client’s record that can be accessed any time with permission.</p>
<p>Data Systems (integration of program data, centralization, etc.)</p>	<p>Data has been an issue due to hardships with getting the data in a timely manner and getting it imputed correctly. The Data Coordinator now checks the Data Base for each site that needs to get follow up information and tells site staff if they need to get further information. NPHS is also making efforts to create electronic forms for sites rather than paper forms. This will speed up the process of getting follow-up information because the data will be readily available. The current system is such that data can be entered weeks after the service is actually provided. After electronic records are instituted follow-up information can be assessed immediately without any lag due to mailing.</p>
<p>Staffing (new training focuses, staffing structures, qualifications for new hires, etc.)</p>	<p>The current plan for future sustainability is the recruitment of different types of counselors to establish a third party billing system which will generate revenue to keep sites functioning and ensure that the S&BI continues in the Healthy Start system.</p> <p>The training of Staff with the Brief Intervention was very informative and adequate. There has not been any staff turnover at the different sites. These are the people who provide the Screening and Brief Intervention and have gotten very adept at providing the service. Videos were provided with examples of the intervention that staff found extremely valuable. The all staff training held focused more on the Screening and different ways of using motivational interviewing to get clients to disclose alcohol use.</p>

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The prevention on women drinking during pregnancy to stop the instances of FASD has gotten good publicity because of the integration of this initiative into the NPHS program. Every time NPHS is talked about the FASD prevention initiative is talked about also. The program and organization has been invited to speak about FASD and prevention in the community and has had a great deal of interest. The trainings which took place for all staff were opened up to the public and were part of a conference held for NPHS. Staff were invited to attend several different groups across the state and now have representation in several state wide initiative in South Dakota. Not only does the Initiative provide a service it provides exposure and education to each community served by a NPHS site.