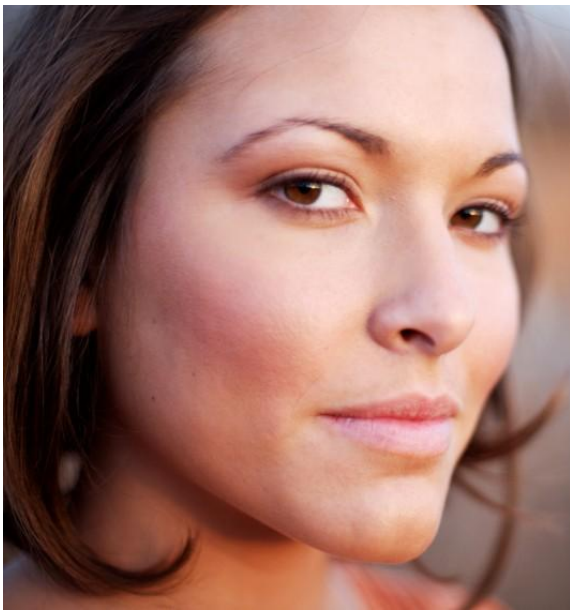
Implementing CHOICES
in clinical settings that serve American Indian and Alaska Native women of childbearing age



Report, Implementation Plan, and Resources

National Organization on Fetal Alcohol Syndrome

Implementing CHOICES in clinical settings that serve American Indian and Alaska Native women of childbearing age

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August 2014

National Organization on Fetal Alcohol Syndrome

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Contents

1. Executive Summary

As part of a Cooperative Agreement between the Centers for Disease Control and Prevention (CDC) and the National Organization on Fetal Alcohol Syndrome (NOFAS), NOFAS has prepared this report describing the considerations for implementing CHOICES—a prevention program that targets women at risk of having an alcohol-exposed pregnancy before they become pregnant—in clinical settings serving American Indian and Alaska Native (AI/AN) women of childbearing age.

CHOICES has proven effective in reducing alcohol-exposed pregnancies and therefore has the potential to decrease the incidence of fetal alcohol spectrum disorders (FASDs), among the nation's leading preventable birth defects and developmental disabilities. Some AI/AN tribes and communities have experienced a higher incidence of alcohol-exposed pregnancies than other populations and the CDC is interested in the possibility that CHOICES will increase motivation to reduce or stop drinking and/or to use birth control effectively among AI/AN women as it has in other populations over the past decade.

Drawing on its wide-ranging relationships with AI/AN leaders, service providers, and activists, NOFAS conducted telephone interviews, assembled a group of key *Informers* in a Tribal Advisory Committee, and held a one-day meeting to gather information and insights essential to understanding how to effectively implement CHOICES in clinical settings serving AI/AN women, and to developing this report.

The *Informers* were selected by NOFAS based on established relationships with tribal organizations and leaders and their ability to provide guidance or input. The Tribal Advisory Committee, consisting of *Informers* and individuals they recommended, met in Washington D.C. to participate in a moderated discussion about their experience with alcohol screening and brief intervention (SBI) (CHOICES is an extended form of a brief intervention) and what factors facilitate successfully implementing the CHOICES intervention in AI/AN communities.

The report brings together information obtained in the *Informer* interviews and Tribal Advisory Committee Meeting, material from CDC, CHOICES grantees, and information from other respected sources in the areas of alcohol SBI, CHOICES, AI/AN women's wellness, and FASDs (see the Available Resources section for a list of resources that informed this report). The report includes an implementation plan section divided into three stages: pre-implementation, implementation, and post-implementation or ongoing work outlining the essential considerations for implementing CHOICES among AI/AN women.

2. Introduction

National Organization on Fetal Alcohol Syndrome (NOFAS)

NOFAS is a non-profit public health advocacy organization dedicated to preventing alcohol-exposed pregnancies and fetal alcohol spectrum disorders and to supporting individuals, families, and communities affected by alcohol-related birth defects. For 25 years, NOFAS has developed and implemented prevention and intervention initiatives among diverse populations nationwide.

NOFAS has extensive relationships and experience working with tribes and tribal organizations and entities. More than fifteen tribal leaders and respected elders have served on the NOFAS Board of Directors since 1990. Since its founding, NOFAS has developed materials and implemented programs in conjunction with tribes such as the Navajo Nation, Cherokee Nation, Standing Rock Sioux Tribe, Oneida Nation, Mississippi Choctaw, Nez Perce, and many others and worked closely with the National Indian Health Board, National Congress of American Indians and National Indian Gaming Association to address FASDs.

Fetal Alcohol Spectrum Disorders

Fetal alcohol spectrum disorders (FASDs) is an umbrella term describing the range of effects that can occur in an individual whose mother drank alcohol during pregnancy. These effects can include physical, mental, behavioral, and/or learning disabilities with possible lifelong implications.

When a pregnant woman drinks alcohol, so does her unborn baby. Alcohol in the mother's blood passes through the placenta to the baby through the umbilical cord. Drinking alcohol during pregnancy can cause miscarriage, stillbirth, and a range of lifelong conditions, known as FASDs. The disorders may include physical, mental, behavioral, and/or learning disabilities. FASDs are completely preventable. If a woman doesn't drink alcohol while she is pregnant, her child cannot have an FASD. There is also no safe time and no safe kind of alcohol to drink during pregnancy.

It is not known exactly how many people have FASDs. CDC studies have documented prevalence rates for fetal alcohol syndrome, the most complex outcome from prenatal alcohol exposure under the umbrella of FASDs, ranging from 0.2 to 1.5 cases per 10,000 live births in certain areas of the United States, including some AI/AN populations. (See the Available Resources section for links to these prevalence studies.) Very few estimates for the full continuum of FASDs are available. In a 2009 review, experts estimated from data of available in-person studies that prevalence rates for the full continuum of FASDs might be as high as 20-50 per 1,000 school children (or 2%-5%) in the U.S. FASDs occur at all income levels and in all types of homes and families in the U.S. In general, research (and clinical wisdom) indicates that rates of FAS/FASDs tend to be much higher among certain AI/AN populations compared to the general U.S. population. This is a factor that can be addressed through education and community participation in prevention programs such as CHOICES.

CHOICES

CHOICES[1] is a program for women that addresses choosing healthy behaviors in order to prevent alcohol-exposed pregnancies. It has been found to be effective at reducing the risk for an alcohol-exposed pregnancy among high risk preconceptional women of childbearing age (18-44 years). At the heart of the CHOICES intervention is the use of motivational interviewing, a form of counseling that relies upon collaboration with the client. It starts with building trust between the counselor and client and moves to identifying, looking at, and resolving uncertainty about changing certain behaviors. The behaviors discussed/addressed in CHOICES are risky drinking and ineffective or no contraceptive use. It includes two to four counseling sessions plus a visit with a family planning services provider. The sessions use activities that have been effective in promoting change in risky health behaviors.

CHOICES History

Prior to the development and implementation of CHOICES, most efforts to prevent the effects of an alcohol-exposed pregnancy focused on intervening with women who were still drinking after they learned they were pregnant. To address this gap in services, the FAS Prevention Team at CDC and collaborators with expertise in working with women drinking at risky levels developed CHOICES. CHOICES is unique in that it intervenes *before* a woman becomes pregnant to reduce her risk of an alcohol-exposed pregnancy. Another unique feature is that it focuses not only on drinking behavior before pregnancy, but also addresses use of contraception.

The CHOICES efficacy trial (results published in 2007) was conducted in six different types of settings: jails/correctional systems, drug and alcohol treatment centers, suburban primary care practices, a hospital-based gynecology clinic, a Medicaid health maintenance organization, and a sample recruited through the media.

Development of the intervention took place over three phases: conducting an epidemiological survey, a feasibility study, and the efficacy/randomized control trial that found the intervention to be efficacious. Results from each of these three activities are provided as Appendix A.

In 2013, CHOICES was accepted for inclusion in SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP), a searchable online database of mental health and substance abuse interventions. The purpose of NREPP is to help the public learn more about available evidence-based programs and practices and determine which of these may best meet their needs.

3. Background

Indian Health Service

AI/ANs have a unique relationship with the federal government due to historic conflict and subsequent treaties. Tribes exist as sovereign entities, but federally recognized tribes are entitled to health and educational services provided by the federal government. The Indian Health Service (IHS)

[1] The CHOICES name was initially an acronym that stood for ***C****hanging* ***H****igh-Risk Alc****O****hol Use and* ***I****ncreasing* ***C****ontraception* ***E****ffectiveness* ***S****tudy*. It is now simply referred to as *CHOICES*.

is charged with serving the health needs of these populations, but more than half of AI/ANs do not permanently reside on a reservation, and therefore have limited or no access to IHS services.

IHS serves members of the 566 federally recognized tribes, roughly 2.1 million AI/ANs residing on or near reservations. The IHS system consists of the following components:

- *Direct health care services*. IHS services are administered through a system of 12 Area Headquarters and 168 IHS and tribally managed service units.
- *Urban Indian health care services and resource centers.* There are 33 urban programs, ranging from community health to comprehensive primary health care services.

AI/AN Women and Alcohol and Substance Use Disorders and Reproductive Health Issues

Alcohol use among AI/AN women is viewed as a significant public health issue, particularly when examined in the context of the estimated prevalence of fetal alcohol spectrum disorders among this population. High rates of alcohol use and binge drinking as well as low rates of reliable contraceptive use put women at high risk for having an alcohol-exposed pregnancy. Patterns of drinking found in pregnant AI/AN women are particularly alarming. The Indian Health Service found that between 47% and 56% of patients reported drinking alcohol during their pregnancies.

The 2011 National Survey on Drug Use and Health found an interesting paradox regarding alcohol use in the AI/AN population. General rates of alcohol use, as defined by reported drinking of any alcohol, were found to be lower in the AI/AN population (44.7%) than in the general population among all races (51.8%). However, the reported rates of binge drinking among the AI/AN population (24.3%) was higher than that of any other examined race. The same pattern was found among AI/AN subjects who were dependent upon or had abused a substance (16.8%). For additional information on this data, see the Available Resources section.

Alcohol Use Among Women of Childbearing Age

CDC and Substance Abuse and Mental Health Services Administration (SAMHSA) studies find that as many as 3.4% of pregnant women report binge[2] drinking. CDC also finds that 15.0% of nonpregnant women of childbearing age report binge drinking in the 30 days prior to the survey. Alcohol use prior to pregnancy is a strong predictor of alcohol use during pregnancy. Most women do not realize they are pregnant until 4-6 weeks gestation and may expose their developing baby to high levels of alcohol during this period. In the United States half of all pregnancies are unplanned. For this reason, women of childbearing age should not drink alcohol if they are trying to become pregnant or are sexually active and do not use effective birth control.

[2] A "binge" is a pattern of drinking alcohol that brings blood alcohol concentration (BAC) to 0.08 gram percent or above. This typically happens when men consume five or more drinks, or women consume four or more drinks in about 2 hours.

Alcohol Screening and Brief Intervention (SBI) Overview

Traditional addiction treatment focuses on helping people who are dependent on alcohol and other substances, and brief interventions—or short, one-on-one counseling sessions—work well with people who drink in risky patterns or ways that are harmful. While traditional addiction treatment lasts many weeks or months, brief interventions can be given in a matter of minutes, and require minimal follow-up. Brief interventions generally aim to moderate a person's alcohol consumption to sensible levels and to eliminate harmful drinking practices (such as binge drinking), rather than to insist on complete abstinence from drinking—although abstinence may be encouraged, if appropriate. Reducing levels of drinking or changing patterns of harmful alcohol use helps to reduce the negative outcomes of drinking. For example, abstinence form alcohol is recommended for women who are pregnant or might become pregnant.

Brief interventions may include approaches—such as motivational interviewing used in CHOICES—designed to engage women who are resistant to moderating their alcohol intake or who do not believe they are drinking in a harmful or hazardous way in a caring conversation. Motivational interviewing encourages patients to decide to change for themselves by using empathy and warmth rather than confrontation. Clinicians also can assist patients by helping them establish specific goals and build skills for modifying their behaviors.

Government Performance and Results Act: FASD Prevention Data

The Government Performance and Results Act (GPRA) requires Federal agencies to demonstrate that they are using their funds effectively toward meeting their missions. The Indian Health Service (IHS) has established GPRA performance goals and targets, including measures of outcomes and output such as diabetes, cancer, and alcohol screening measures. The IHS refers to its alcohol screening measure as fetal alcohol syndrome prevention. The alcohol screening/FAS prevention measure provides an important incentive for IHS health care delivery sites to consider an intervention such as CHOICES.

4. CHOICES Tribal Advisory Committee Meeting

Informer Interviews

NOFAS interviewed 11 individuals, 8 of whom are American Indian or Alaska Natives, with experience working in AI/AN clinics, backgrounds in prevention, and/or the ability to provide guidance or input for developing specific elements of the CHOICES AI/AN Implementation Plan. (A list of interviewees, also referred to as *Informers*, is included as Appendix B at the end of this document.) The one-hour interviews included questions about alcohol SBI in AI/AN clinics, FASDs in AI/AN communities, and potential barriers to implementing CHOICES in AI/AN clinics or other settings. The *Informers* were also asked to provide names of colleagues to serve on the CHOICES Tribal Advisory Committee, a group that would engage in a more detailed discussion of implementing CHOICES in clinical settings that serve AI/AN women of childbearing age. (A synopsis of the questions and responses from the *Informer* interviews is included as Appendix C at the end of this document.)

CHOICES Tribal Advisory Committee Selection

The goal of the CHOICES Tribal Advisory Committee Meeting was to obtain more in-depth input of participant experience with SBI (CHOICES is an extended form of a brief intervention) and thoughts on what needs to happen in order to develop a CHOICES implementation plan with specific details and input from members of AI/AN communities.

Members of the CHOICES Tribal Advisory Committee were selected from the list of *Informers* and the individuals they recommended. In choosing the group, NOFAS looked for members with strong tribal/community connections and a passion for prevention from diverse backgrounds, tribal affiliations, and geographic locations. The final group consisted of nine women, including representatives from the Eastern Band Cherokee, Tlingit, Six Nation, Oglala Sioux, and White Earth Nation. In addition to the committee members, staff from NOFAS and CDC, and a representative from Indian Health Service attended the meeting, not as active participants, but to support the meeting and answer questions related to CHOICES and the meeting's goal. (A list of the CHOICES Tribal Advisory Committee members, also referred to as *Advisors*, CDC and NOFAS staff, and observers, is included as Appendix D at the end of this document.)

CHOICES Tribal Advisory Committee Meeting

The CHOICES Tribal Advisory Committee met on August 9, 2013 in Washington D.C. at the office of Hobbs, Straus, Dean & Walker, LLP, a law firm dedicated to issues impacting Indian Country. One of the firm's partners, a NOFAS Board Member, graciously offered a well-appointed board room in which to meet. Prior to the meeting NOFAS and CDC staff created an outline for the meeting, including an agenda and a list of general questions for a meeting moderator to explore. The general themes for discussion were: 1) members' experience with alcohol screening and brief intervention and 2) thoughts on what would need to happen in order for a clinic to successfully implement the CHOICES intervention. (The moderator questions for CHOICES Tribal Advisory Committee Meeting are included as Appendix E at the end of this document.) The purpose of the meeting was to discuss a range of options and opinions, not to come to consensus on a singular method of or pathway to implementation. Notes were taken on the main points made in the meeting.

The meeting began with introductions, an opening intention offered by *Advisors* Carolyn Hartness and Suzie Kuerschner, and context setting to prepare members for the discussion ahead. After these preliminary agenda items, the moderator, Gaylon D. Morris, began the discussion. Mr. Morris, principal of MorSolutions, has collaborated extensively with CDC and has concentrated experience in the areas of public health, public policy, and partnership development.

Response Highlights

Both *Informers* and *Advisors* were thankful for the opportunities to share their thoughts and experiences. While strict consensus was not sought on how to introduce and implement the CHOICES intervention, many themes developed from the discussions. These themes included the need to:

- *Build and maintain trusting relationships* within the community. It is important to find *champions* who will support and endorse CHOICES.

- *Use a multigenerational approach in planning and implementation*. *Advisor* quote: "*If all generations don't buy into a behavior change, it will create conflict."*

- *Include local resources, cultural traditions, and cultural activities in the intervention.* For example, the Oglala Sioux in South Dakota are currently working with CDC to create a talking circle version of CHOICES.

- *Determine community health and prevention priorities* through discussions with Elders, community members, and health providers and/or by conducting a community readiness assessment. (A sample of a tool to assess readiness to implement CHOICES is included as Appendix F.) One *Advisor* suggested that AI/AN communities develop standards for culturally based care, i.e., a list of standards to measure all potential programs/interventions (e.g., Do the p*rograms/interventions address larger community concerns, such as healing? Can the program be adapted to include cultural traditions?).*

Advisors also perceived numerous benefits from the CHOICES intervention:

- Low in cost
- Identifies real and potential alcohol problems
- Motivates patient to change rather than a provider directive
- Offers a solution to patient
- Can be performed by variety of health care workers (e.g., physicians, nurses, certified addictions professionals, social workers)
- Can be performed in a variety of settings (e.g., primary care office, outpatient facility, emergency room, detention center)

5. Implementation Plan with Informer and Advisor Suggestions

Once a community has determined their need and readiness for implementing a prevention program such as CHOICES, there are many steps to getting started such as mobilizing community support, finding the best home for the project, figuring out how it will be staffed, and calculating the costs involved. In this section we look at the three phases of implementation: pre-implementation, implementation, and post-implementation (or ongoing work), and provide some of the steps involved and suggestions from the *Informers* and *Advisors*, and previous CHOICES grantees.

Pre-Implementation

Pre-Implementation is the period when stakeholders and decision makers among a specified tribe or community are identified and organized to determine the plan for implementing CHOICES within the administrative and cultural context of the community. The pre-implementation phase may take from several months to over a year. Steps involved in the pre-implementation phase include:

- *Educate community members, Elders, healthcare workers, and others about the CHOICES intervention. Informers and Advisors suggested the following information and resources:*
  - Traditional storytelling emphasizing healthy future generations

- Personal stories or testimonials about FASDs, the power of prevention, or from someone who has already implemented CHOICES in their community. (Storytelling and testimonials can provide the motivation and purpose to go forward beyond the clinical rationale.)
- FASD prevalence data (*http://www.cdc.gov/ncbddd/fasd/data.html*)
- Information on the cost of FASDs over a lifetime (*http://fasdcenter.samhsa.gov/documents/RickHarwoodPresentation.pdf*)
- Information on the effectiveness of the CHOICES intervention
- Benefits to adopting CHOICES in your community

- *Determine where CHOICES will fit (site). Advisors* emphasized the importance of environment and the need to choose a site that limits stress. Consider locating CHOICES with an established program (e.g., Women, Infants and Children (WIC), Healthy Start) in order to build upon a staff that has already developed rapport and trust with clients. CHOICES has been successfully implemented in conjunction with a variety of community programs and from a variety of settings including:
  - Suburban primary care practices
  - STD clinics
  - Community health centers
  - Family planning clinics
  - Drug/alcohol treatment centers
  - Jails
  - Hospital-based gynecology clinics (One *Advisor* suggested that CHOICES would be a natural fit as part of a woman's first post-partum visit.)

- *Build relationships with IHS, other healthcare providers, and members of community organizations.* Share information on CHOICES and encourage support and referrals.

- *Create site readiness by assessing current office systems, staff, and culture and making plans to assimilate CHOICES components and principles at each level.*

- *Develop plans and guidance for referrals:*
  - Become familiar with addiction services/providers in your community
  - Create a local resource list of treatment centers and providers, including contact information, for office staff
  - Maintain a resource list
  - Develop a standard referral form or adapt one that your office is currently using
  - Develop a tracking system within your office to follow-up on referral compliance

- *Discuss possible modifications to CHOICES*. One *Advisor* who works with the Oglala Sioux CHOICES program in South Dakota, noted that they made language changes to better reflect local terms/usage (e.g., in written materials, they took out *brandy* and replaced it with *juices*—slang for fruity alcoholic beverages).

- *Determine who will be responsible for the various parts of the intervention.*

- *Map out procedures and work flow. Advisors* made the following suggestions:
  - Write CHOICES responsibilities/duties into job descriptions, so that even if a key supporter of the program leaves, it will continue.
  - Have services available on a walk-in basis.

- *Decide what information you will need to collect to determine the effectiveness of the intervention and how follow up will be handled.* Grant recipients will receive specific guidance from their funder on what information is required for them to collect and submit (things like the number of women: screened, completing the intervention, reporting a reduction in drinking, reporting effective contraceptive use). Other suggestions from *Advisors* and former grantees include:
  - Obtain training in basic program evaluation.
  - Use quality assurance (QA) and quality control (QC) to obtain consistent/useful data.
  - Use feedback to modify and streamline the work processes.
  - Use incentives (e.g., gift certificates to local stores) to improve follow up rates.
  - Update computers to collect, update, and compile the needed information.

- *Determine training standards, needs, and resources (e.g., the CDC CHOICES curricula)*
  - Establish standards for training
  - Determine who will train (e.g., staff, expert trainers, resource centers)
  - Plan for training updates and new employee trainings
  - Determine who needs to be trained and what information needs to be provided.
  -

- *Schedule and conduct training.* CHOICES grantees made the following suggestions:
  - Build training into regional meetings
  - Get your training on agendas of other agencies
  - Consider collaborating with other agencies for training
  - Consider the following to meet training needs: consultants, the FASD State Coordinators, experienced staff, train the trainers methods, resources through State universities, and collaborating with other sites to create a training video.

- *Provide education regarding alcohol and pregnancy.* Complement the intervention by planning to provide education materials in waiting areas and client rooms regarding the risks of drinking during pregnancy. (Posters, pamphlets and other materials outlining the effects of alcohol on the developing baby and fetal alcohol spectrum disorders are available at no cost from the National Organization on Fetal Alcohol Syndrome (www.nofas.org) and can be customized with your own logo and information.)

- *Decide how CHOICES will be sustained.* Consider the following sources and strategies for sustaining the program:
  - Money from *Healthy Start* and a priority population SAPT [Substance Abuse Prevention and Treatment] Block Grant
  - Grants from CDC and SAMHSA
  - Funding through the State Lottery (obtained in Arizona through legislation)

- By integrating FASD prevention into the statewide reconfiguration to a behavioral-health-focused system

Implementation

Implementation is the period during which it has been determined that a site has the necessary administrative and clinical infrastructure and all of the decisions made during the pre-implementation period are put into action. The implementation should be carried out as was determined in the pre-implementation phase. Barriers that are identified during implementation should be documented. Some of the specific things needing attention during this phase include:

- Training for all clinic staff on FASDs and the role of the CHOICES program in preventing alcohol-exposed pregnancies
- Training on how to conduct screening and assessment for eligibility should also be provided to those who will do this step if it is someone other than the interventionist
- Training on how to conduct the intervention should be provided for those who will be interventionists
- Making necessary physical changes to the setting(s) to be used for the intervention
- Training on referral resources and making referrals
- Operationalizing the intervention with patients

An *Advisor* from an AI/AN community that partnered with IHS to implement CHOICES in three clinics stressed that it has been positive for her community, noting that *CHOICES is non-judgmental and empowers women to make good choices*.

IMPLEMENTATION CHALLENGES: Some of the implementation challenges mentioned by the *Advisors* included ensuring staff comfort levels, tracking client reactions, and organizing the large quantity of project forms.

Post-Implementation

Post-Implementation (or ongoing work) is a time for reflection and measurement. This phase includes everything that is needed to keep the program going and to further customize it to meet the needs of your community. Tasks associated with this phase include:

- Collecting data including follow up with former clients
- Reviewing and evaluating data
- Providing staff support and stress reduction
- Improve project flow and participation
- Meetings with community, stakeholders, providers
- Training
- Reporting success to Elders, champions, sponsors, community
- Face challenges in changing an agency's culture
- Use focus groups to inform leadership

- Allow policies and procedures to change as needed
- Tie policies and procedures into new and existing contracts
- Work on personal resistance/discomfort at asking clients “difficult” questions
- Support sites’ different cultures to best meet the needs of the agency, staff, and clients
- Share successes of the program/importance of the program with staff, clients, and community

6. Conclusion

CHOICES has proven to be successful at reducing alcohol-exposed pregnancies, although to date it has only been implemented in one site serving AI/AN women. In order to understand if broader implementation of CHOICES among tribes and urban Indians is appropriate and feasible, NOFAS called on AI/AN leaders, service providers, and advocates to provide input and recommendations.

While both *Informers* and *Advisors* were overwhelmingly positive about CHOICES, they agreed that there are many important steps to ensuring successful intervention, including endorsement from national organizations such as the National Indian Health Board, backing by the tribal council or other entity with oversight over the implementation site, and flexibility to accommodate cultural considerations without compromising CHOICES. Additional fundamental considerations for potential clinical practices are assessing readiness including the qualifications of personnel and whether CHOICES is appropriate for the patient population and if that population will yield sufficient outcomes to measure the intervention’s effectiveness.

This report summarizes the perspective of the *Informers* and *Advisors* and incorporates it into a three-phase implementation plan or outline for effectively placing CHOICES into practice with AI/AN women.

7. Frequently Asked Questions

Why does CHOICES focus on women? This is because it is a pre-conception approach, to reduce women's risk BEFORE they get pregnant, especially since women often don't know they are pregnant until several weeks in to the first trimester, and thus damage may have already occurred. We do recognize the important role that men may play in women's drinking behavior and are often asked about this.

Can CHOICES be tailored to better fit a community or setting? Absolutely! And, it is highly encouraged. There are several considerations where tailoring may be needed. Some of the factors are the "clinic flow", staff and time availability, etc. Tailoring also includes modifying things like the drink chart of common drinks to include those that the women being targeted are drinking, literacy/language that is culturally sensitive and appropriate, the organization and format of the Client Workbook materials, as well as the graphics used for them.

How does CHOICES deal with the possible need for referrals to social services and/or substance abuse treatment? CHOICES sites are strongly encouraged to develop plans and guidance for referrals as part of their initial planning process, so that they have a plan in place when these referrals are needed.

Why is drinking reduction a positive outcome if no drinking at all during pregnancy is recommended? Drinking reduction below risky levels is considered a positive outcome in CHOICES because of the fact that it is a "pre-conception" approach, and a "harm reduction" approach. Since we are targeting women who are not currently pregnant, we are not going to tell them that they can't drink. We also know that some women aren't ready to reduce or stop drinking, thus using effective and consistent contraception to prevent an AEP is an appropriate "option.". Through CHOICES, women are advised that if they could become pregnant (because they are sexually active and not using effective and consistent (that is, all partners, every time) contraception), they should not drink alcohol. And, they are certainly given the "no safe time, no safe amount" message.

What makes CHOICES unique? CHOICES works with women before they become pregnant to reduce their risk for an AEP. Many women do not know they are pregnant until well in to their first trimester when damage may have already occurred. Because it uses a harm reduction approach it does not require women to stop drinking completely, increasing the likelihood they will be successful at reducing their risk for an AEP. CHOICES also addresses contraception use. This dual-focused approach to preventing alcohol-exposed pregnancies is unique to CHOICES.

Can CHOICES be used with women who are pregnant or trying to become pregnant? CHOICES works by encouraging effective contraception and/or drinking below risky levels in non-pregnant women. Women who are pregnant or trying to get pregnant are advised that there is no known safe level of drinking during pregnancy. There are other interventions to help pregnant women stop drinking.

Is the family planning visit essential? The program gives women a choice between reducing or stopping drinking and/or using effective contraception to reduce their risk for an AEP. It is essential that contraceptive services be made available for the women participating in the program. Clinics without on-site services can link with external providers for contraceptive care.

Can CHOICES be used with teens? Although it was not tested with teens younger than age 18, some programs are doing so. Some key considerations are:

- Your program's guidelines about discussing alcohol use with underage women
- Contraceptive methods available for this age group (younger women may not be eligible for all types of birth control) In addition, sexual relations between underage teens and older boys or men may be a reportable crime in some states

You need to:

- Know your reporting responsibilities
- Inform clients of your need to report sexual or drinking behavior.

8. Available Resources

Information on CHOICES

- CHOICES Fact Sheet: http://www.cdc.gov/ncbddd/fasd/documents/choices_onepager_-april2013.pdf
- CHOICES Curriculum: The CHOICES curriculum includes a Facilitator Guide for trainers, a Counselor Manual and Client Workbook. A data tracking and monitoring system allows clinics to follow a client's progress and evaluate their success in reducing risks for an AEP http://www.cdc.gov/ncbddd/fasd/freematerials.html
- Inclusion of CHOICES in SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP) http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=348
- CDC Web Site: Additional resources can be found at www.cdc.gov/fasd

Information on Fetal Alcohol Spectrum Disorders:

- National Organization on Fetal Alcohol Syndrome (NOFAS) www.nofas.org

Information on the Prevalence of FAS:

- CDC. Fetal alcohol syndrome-United States, 1979-1992. MMWR Morb Mortal Wkly Rep. 1993;42(17):339-41.
- CDC. Update: Trends in fetal alcohol syndrome-United States, 1979-1993. MMWR Morb Mortal Wkly Rep. 1995;44(13):249-51.
- CDC. Surveillance for fetal alcohol syndrome using multiple sources-Atlanta, Georgia, 1981-1989. MMWR Morb Mortal Wkly Rep. 1997;46(47):1118-20.
- CDC. Fetal alcohol syndrome-Alaska, Arizona, Colorado, and New York, 1995-1997. MMWR Morb Mortal Wkly Rep. 2002;51(20):433-5.

Information on alcohol screening and brief intervention:

- CDC's Alcohol Screening and Brief Intervention Efforts http://www.cdc.gov/ncbddd/fasd/alcohol-screening.html
- CDC's *Planning and Implementing Screening and Brief Intervention for Risky Alcohol Use: A Step-by-Step Guide for Primary Care Practices* http://www.cdc.gov/ncbddd/fasd/documents/alcoholsbiimplementationguide.pdf
- NIAAA's *Helping Patients Who Drink Too Much: A Clinician's Guide* (Updated 2005 Edition) http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/clinicians_guide.htm
- NIAAA's *Rethinking Drinking* http://pubs.niaaa.nih.gov/publications/RethinkingDrinking/Rethinking_Drinking.pdf

Information on Women and Alcohol

- The American College of Obstetricians and Gynecologists http://www.womenandalcohol.org/
- NIAAA Fact Sheet – *Women and Alcohol* http://pubs.niaaa.nih.gov/publications/womensfact/womensfact.htm

Related Publications

- Project CHOICES Research Group. Alcohol-exposed pregnancy: characteristics associated with risk. Am J Prev Med. 2002 Oct; 23(3):166-73.
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9. Appendices

APPENDIX A: History of CHOICES

1997-2001

CDC awarded three-year cooperative agreements* to Nova Southeastern University, University of Texas Health Science Center at Houston, and Virginia Commonwealth University to collaboratively conduct an epidemiological survey and the Project CHOICES Feasibility Study. The selected settings had access to relatively large numbers of women of childbearing age who drank at high-risk levels and did not use contraception effectively.

The objectives of the study were to:

- Characterize the women in the special high-risk settings.

- Reduce the rate of alcohol consumption among women who are not using contraception effectively and increase contraception effectiveness among women who do not reduce their alcohol consumption.
- Examine the relationship between selected process variables and study outcomes.

The CHOICES epidemiological survey confirmed a 6-fold increased risk for alcohol-exposed pregnancies among women in targeted community-based settings as compared to childbearing-aged women overall (12.5% versus 2%). Respondents were 2672 English-speaking women aged 18 to 44 years from six settings, including an urban jail, a drug/alcohol treatment facility, a gynecology clinic, two primary care clinics, and respondents to a media solicitation.

More information can be found in the following publication: Project CHOICES Research Group. Alcohol-exposed pregnancy: characteristics associated with risk. *American Journal of Preventive Medicine* 2002:23(3): 166-173.

The CHOICES Feasibility Study was conducted to develop, implement, and evaluate the intervention and found that 65% of women receiving the intervention reduced their risk of an alcohol-exposed pregnancy at 6-months follow-up.

More information can be found in the following publication: Ingersoll K, Floyd L, Sobell M, Velasquez M, Project CHOICES Intervention Research Group. Reducing the risk of alcohol-exposed pregnancies: A study of a motivational intervention in community settings. Pediatrics 2003;111(5):1131-1135.

2002-2005
CDC awarded 3-year cooperative agreements to the same universities to test the efficacy of the Project CHOICES intervention in a randomized controlled trial.

The CHOICES Efficacy Study was conducted to determine how well the intervention worked in the study group vs. the control group. Some of the participants received information plus a brief motivational intervention, while others received only information. The brief motivational intervention consisted of four counseling sessions and one contraception consultation and services visit:

- In-depth assessment of alcohol use and contraceptive use patterns.
- Counseling about the consequences of alcohol use during pregnancy.
- Brief advice and counseling for moderate-to-heavy drinkers to reduce intake levels, or referral to community treatment services for alcohol-dependent drinkers.
- Reproductive health education about contraceptive methods, provision of contraceptive services, and client follow-up.

The group that received both information and a brief motivational intervention were twice as likely to be at reduced risk for an alcohol-exposed pregnancy compared to the group that received only information. Odds ratios were significant at all three follow-up phases: 3 months, 2.32 (95% CI: 1.69, 3.20); 6 months, 2.15 (95% CI: 1.52, 3.06); and 9 months, 2.11 (95% CI: 1.47, 3.03). These results showed that a brief motivational intervention can reduce the risk of an alcohol-exposed pregnancy.

More information can be found in the following publication: Floyd RL, Sobell M, Velasquez M, Ingersoll K, et al. Preventing alcohol-exposed pregnancies: a randomized controlled trial. *American Journal of Preventive Medicine* 2007;32(1):1-10.

2007-2010

CDC developed and pilot tested the CHOICES curriculum based on the protocols of the efficacy and randomized controlled trials. Feedback and lessons learned from a series of four (4) pilot trainings informed the final curriculum. Pilot trainings included staff who provide trainings on FASD-related topics, and staff from substance abuse treatment and prevention programs as well as those who work in tribal health programs, STD clinics and other public health systems of care. The curriculum includes a Facilitator Guide and videos for the trainer, and a Counselor Manual and Client Workbook for the CHOICES counselor/interventionist.

2009

Translation of CHOICES is initiated to determine if the intervention is feasible in "real-world" public health settings and in settings other than those studied in the efficacy and randomized controlled trials.

2009-2012

SAMHSA's FASD Center for Excellence funded six substance abuse treatment centers to implement CHOICES. CDC provided training for these sites. More information about this work can be found at http://fasdcenter.samhsa.gov/assessmentprevention/fasdprevention.aspx.

2009-2013

In 2006, 19 million new cases of STDs occurred; half of these were among people 15 through 24 years of age. Women 18 through 24 years of age are in their peak childbearing years and, according to a national survey in 2005, had the highest levels of binge drinking (21.3%) among all age categories of women 18 through 44 years of age. National data also indicated that the rate of STDs among female heavy drinkers was 7.3%, with rates highest among women 18 through 25 years of age. In this same age group the rate of STDs among female non-drinkers was 2.1%. These data suggest the importance of incorporating alcohol interventions into high-risk settings where other related risk behaviors also are addressed.

Given the potential to reach large numbers of women at high risk for an AEP, two public health departments were funded to adapt and implement the intervention within their STD clinic populations. They were: Colorado Department of Public Health and Environment in collaboration with the Denver Metro Health Clinic, and Baltimore City Health Department in collaboration with Johns Hopkins University School of Medicine, Baltimore, Maryland.

2010-2013

CDC entered into to an Inter-Agency Agreement with the Indian Health Service (IHS) to implement and CHOICES in clinics settings serving American Indian and Alaska Native women.

2010-2014

CDC funded AltaMed Health Services Corporation, Los Angeles, California and New York City Health and Hospitals Corporation, New York, New York to develop and implement interventions for women of childbearing age who are at risk for an alcohol-exposed pregnancy.

2011

CDC released the CHOICES Curriculum. As of July, 2014, over 8,000 sets of the curriculum have been distributed.

2013

CHOICES accepted for inclusion in SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP)

ICF Macro released the results of a cross-site evaluation assessing integration of CHOICES into STD clinic and Family Planning clinic sites.

CDC developed and implements a CHOICES Training of Trainers (ToT) curriculum.

CDC funded NOFAS through a cooperative agreement to develop a report and implementation plan incorporating strategies for implementing CHOICES in clinical settings that serve American Indian and Alaska Native women of childbearing age.

CDC released an FOA titled, "Advancing Alcohol Screening and Brief Intervention and CHOICES in American Indian and Alaska Native Populations through Training and Technical Assistance". The University of Wisconsin Department of Family Medicine and the Denver Health and Hospital Authority were awarded 4-year cooperative agreements to establish training and technical assistance centers. Each center works with primary care clinics serving AI/AN populations to implement alcohol SBI and CHOICES.

APPENDIX B: Individuals Interviewed During the Informer Interviews, January 18–March 5, 2013

Stacy Bohlen, Executive Director, National Indian Health Board

Christina Chambers, PhD, MPH, Professor, Co-Director, Center for Promotion of Maternal, Health and Infant Development, University of California, San Diego

Therese M. Grant, PhD, Associate Professor, Department of Psychiatry and Behavioral Health, Washington State Parent-Child, Assistance Program, University of Washington School of Medicine

Carolyn Hartness, FASD Educator/Consultant, Port Madison Indian Reservation

Jennifer Hughes, Partner, Hobbs, Straus, Dean & Walker

Suzie Kuerschner, MEd, FASD Educator/Consultant, Port Madison Indian Reservation

Naomi Michalsen, Executive Director, WISH (Women in Safe Homes), Ketchikan, Alaska, Member, Tlingit-Eagle/Wolf Clan

Bobi L. Spaeth, White Earth Reservation, Minnesota

B-G Tall Bear, Native American Family Liaison, Iowa Department of Human Services

Kim Teehee, Partner, Mapetsi Group

Rose Weahkee, PhD, Director, Division of Behavioral Health, Indian Health Service

APPENDIX C: Informer Interviews: Responses and Insights by Question

Please note: Questions 1-5 concerned recommendations for the Tribal Advisory Committee; questions 10 and 11 were about publications and upcoming events. These questions are not included in this summary.

6. Are you familiar with existing alcohol screening and brief intervention strategies in AI/AN clinical practice?

- Have seen many screens used, including T-ACE, TWEAK, and personal interviews.
- All women seen at the Tribal Health Clinic (Ketchikan, AK) are screened for drinking and domestic violence.
- Screening is incorporated into clinic practices.
- Women can be reluctant to share information on their drinking with providers.
- Different screens are being used in different systems. CAGE is used within the Indian Health Service (IHS) system. The GAIN-SS (short screener) is used in systems that screen for mental health and alcohol-related issues.
- What is done with information obtained from the screenings depends on the provider's comfort level and amount of time available.

7. Alcohol screening (FAS Prevention) is a current performance measure in Indian Health Service and tribal clinics. Are you familiar with how this measure is addressed in any IHS or tribal clinical setting?

- CAGE is used within the IHS system.
- If someone screens positive [for dependence] there are no options for referral (Ketchikan, AK).
- Alcohol screening is not standardized. Doctors with time and a comfort level with the topic will screen for/discuss drinking and pregnancy. The health care system is overwhelmed and most providers are struggling to keep up with demand.
- Some communities are not ready to talk about FASDs.
- Regular reminders to screen are helpful/important.
- The Aberdeen area has done a good job with screening, but who does the screening and what type of screening is being used varies.
- Some leaders do not believe that drinking during pregnancy is a problem within their tribes and therefore do not want to discuss screening or prevention methods.
- Screening is not universal and there is resistance among providers and patients.
- The GPRA (Government Performance and Results Act) FASD measure records only if the patient was screened for alcohol use during pregnancy, not the results. If a provider asks to screen the patient and the patient declines, for GPRA data collection purposes the patient is recorded as having been screened.

8. What is your sense of the problem of FASDs in Indian country or among specific tribes or tribal populations?

- FASDs are an overwhelming problem that is being lost among competing priorities and lack of funding.
- FASDs ares not *on the radar* as much as they should be.
- Some communities are not ready to talk about FASDs.
- Discussing FASDs is a complicated issue: there is no cure, people are overwhelmed with competing issues, shame, denial, and guilt are involved…
- Prevention of and issues related to FASDs need to be addressed in a model that provides care at appropriate frequencies and for the needed duration.
- The Collaborative Circle of Care model has worked well in tribal settings.
- Transition from disease intervention to disease prevention focused care is evolving, but slowly. Changing behavior around alcohol consumption is among the most challenging, if not the most challenging, of prevention objectives, making FASDs a lower priority.
- Varies widely among tribes in part based on resources.
- Lack of diagnostic practices makes scope of problem unknown.
- Some tribes resist diagnosis of FAS because they are lacking services to deal with the needs revealed by the diagnosis.

9. What are the beliefs in Indian country toward the use of contraception? Are they consistent or variable?

- Abortion is not generally practiced—children are considered to be blessings brought into the world by the Creator.
- Young people are unlikely to use contraception or be open to discussion about it.
- Use of contraception is considered a private topic.
- Urban and tribal clinics offer and teach contraception.
- *Family planning* should be used instead of *birth control*.
- Attitudes vary widely.
- As part of an IHS contract, attitudes toward family planning were compared. 65 percent of non-Native American women surveyed were using family planning compared to 61 percent of Native American women.
- Discussion of contraception use would not be frowned upon.
- Discussion of family planning should not be mandatory.

12. Can you think of any barriers to (or general advice before) implementing new clinical practices such as CHOICES in tribal/IHS clinics?

- Time and lack of health care providers.
- Silos of specific interests.
- Health care professionals who, even after training, are still not comfortable discussing alcohol use with women.
- Barriers vary by tribe. Need to know if one method of family planning is more popular in a given community.
- Meet with tribal leaders early on.
- Establish an advisory board (or advisory council) made up of AI/AN representatives (e.g., elders, natural helpers, community leaders, service providers, impacted families) for the CHOICES implementation. Include discussion of cultural adaptations.
- For any new project to be successful and sustainable it has to be thoroughly embedded in a community with buy-in from all layers of the community, including teachers.
- All services need to be driven from a community strengths basis.
- Consider all developmental stages of life and combine best practices with Native traditions.
- Project has to be meaningful to clients.
- Successful programs often have a Native cultural component attached to them. These cultural components will vary by tribe.
- Go through people and programs that already have partnerships/relationships. (It might not be a clinic—maybe a sideways approach through another program.)

13. How do you anticipate AI/AN women will respond to a discussion with their health care provider about alcohol use and the use of contraception?

- Discussion needs to be with someone with whom the woman has developed a trusting relationship; otherwise she may fear judgment or prosecution and not be open/honest.
- Some providers are more trusted than others (e.g., a woman may prefer getting her health care in another city or from another tribe as opposed to going to an IHS clinic.)

APPENDIX D: CHOICES Tribal Advisory Committee Meeting Participants, August 9, 2013

Committee Members

Stacy Bohlen, Director, National Indian Health Board

Christina Chambers, PhD, MPH, Professor, Co-Director Center for Promotion of Maternal Health and Infant Development, University of California San Diego

Daphne Colacion, Lake County Tribal Health Consortium, Inc.

Carolyn L. Hartness, FASD Educator/Consultant, Port Madison Indian Reservation, former member of the SAMHSA FASD Center for Excellence Native Communities Expert Panel

Suzie B. Kuerschner, MEd, FASD Educator/Consultant, Port Madison Indian Reservation, former member of the SAMHSA FASD Center for Excellence Native Communities Expert Panel

Naomi J. Michalsen, Executive Director at WISH (Women in Safe Homes) in Ketchikan, Alaska, member of the Tlingit-Eagle/Wolf Clan

Susan Pourier, Oglala Sioux Tribe, Pine Ridge, South Dakota

Bobi L. Spaeth, White Earth Reservation, Minnesota

B-G Tall Bear, Native American Family Liaison, Iowa Department of Human Services

Observer
Carolyn Aoyama, CNM, MPH, Office of Public Health Support, Indian Health Service

Staff
Tom Donaldson, President, National Organization on Fetal Alcohol Syndrome (NOFAS)

Catherine A. Hutsell, MPH, Health Education Specialist, FAS Prevention Team, Centers for Disease Control and Prevention (CDC)

Kathleen T. Mitchell, MHS, LCADC, Vice President and National Spokesperson, NOFAS

Gaylon D. Morris, Principal, MorSolutions; Meeting Moderator

Andrea Savoye, Writer/Editor

APPENDIX E: Moderator Questions for CHOICES Tribal Advisory Committee Meeting

Goal: To obtain input for the development of a CHOICES implementation plan for clinical sites serving American Indian and Alaska Native (AI/AN) women of childbearing age.

Two Themes with sub-topics for probing:

1) In this discussion, **we'd like to learn more about your experience with Alcohol Screening and Brief Intervention, as CHOICES is an extended form of a brief intervention.** If you have knowledge of or direct experience implementing alcohol screening and brief intervention, please tell us how that worked.

a. Introducing the intervention
    i. What was the process for considering adoption of the intervention?
    ii. What factors were considered and which ones were critical for adoption?
    iii. How did you describe "alcohol screening and brief intervention"?
    iv. What kind of resistance and/or support was received?
b. Implementing the intervention
    i. What was the process for planning, implementing and evaluating the intervention?
    ii. We've heard that in many settings the "brief intervention" component is often not completed.
    iii. Why do you think that is? How does that compare to your experience?
c. Wrapping up Topic 1
    i. What are 3 key lessons learned from your experience with alcohol screening and brief intervention?

2) In this next discussion, **we'd like to hear your thoughts on how the CHOICES intervention could be implemented in settings serving non-pregnant AI/AN women of child-bearing age, to prevent alcohol-exposed pregnancies. In particular, we are interested in learning more about what needs to happen in order for a clinic to successfully implement this intervention.**

a. Committing resources
    i. What resources are needed in order to make CHOICES part of the standard of practice in a clinic?
    ii. Are outside resources necessary? If so, where can those resources be obtained?
    iii. What would it take for CHOICES to be sustainable?
b. Building internal support
    i. What modifications or changes to current practice would be necessary to make it happen?
    ii. Who needs to be involved in the decision making process? Who makes the final decision?

iii. What are your thoughts on how receptive staff would be to taking on the responsibilities associated with this intervention?
iv. What training or support would be needed to ensure adoption?

c. Implementing CHOICES
    i. Who should CDC collaborate with to successfully implement CHOICES in clinics serving AI/AN women? Are there specific areas, tribes, clinic settings, etc. where CDC and its partners should focus their efforts?
    ii. What barriers might be faced? What harms might result?
    iii. What would it take for CHOICES to be sustainable and part of the standard of practice in a clinic?
    iv. What referrals for treatment are available for women who need more help to stop or reduce their drinking than CHOICES can provide?
    v. What other benefits, besides preventing alcohol-exposed pregnancies, do you foresee could result from implementing CHOICES? For clients? For staff?
d. Wrapping up Topic 2
    i. In reflecting on what you've heard today, what are the top 3 things that are essential to successfully implement and sustain CHOICES in clinics serving AI/AN women?

APPENDIX F: CAPACITY ASSESSMENT (i.e., Community Readiness) SURVEY (Adapted from the Community Toolbox: http://ctb.ku.edu/en/default.aspx)

This tool is designed to help clinic sites and/or their community partners decide if they are ready to adopt and implement CHOICES. The survey may also be used to assess whether a site is ready to begin or if there are areas that need to be worked on first. For each of the numbered items, circle the most appropriate response for each item ("Good," "Fair," or "Poor"). To determine the most appropriate responses, please consider the supporting questions for each item. For example:
For a "Good" response: clinic sites and/or their partners should have considered most of the supporting questions and have taken some action to address them. **For a "Fair" response:** clinic sites and/or their partners may have considered some of the supporting questions and have brainstormed ways to work on them. **For a "Poor" response:** clinic sites and/or their partners may have not considered most of the issues and still have some work to do before you can answer the questions.

1. The level of support we have from those who will be affected by the intervention is…	**Good**	**Fair**	**Poor**
Before you answer, have you and your partners considered or addressed the following?			
Who is the priority population that will be affected?			
Have we talked with representatives of the priority population about the need to plan and implement an intervention to address the health issue of concern?			
Was there support expressed for planning and implementing an intervention?			
Were any barriers expressed about moving forward with an intervention?			
2. The level of political support we have from key decision makers is…	**Good**	**Fair**	**Poor**
Before you answer, have you and your partners considered or addressed the following?			
Who are the key decision-makers (e.g., organization administrators, legislators, or advocacy groups?)			
Have we talked with these individuals about the need to plan and implement an intervention and asked their opinions on working with the priority population?			

Have we received buy-in from these key decision-makers that shows that they will support your work?			
Have we considered ways to involve key decision-makers in the planning and implementation processes?			
3. The extent to which we've engaged partners (individuals or organizations) to assist us in the planning and implementing of the intervention is…	**Good**	**Fair**	**Poor**
Before you answer, have you and your partners considered or addressed the following?			
Who are the partners we've identified to assist and support planning and implementing an intervention?			
Are individuals or groups with public health experience and other important fields of expertise engaged as partners (e.g., in public policy, education, or social services)?			
Are individuals who will be affected by the intervention engaged as partners to help you plan the intervention?			
Have we thought about how partners will participate in shared decision-making?			
4. The level of administrative support we have from our organization is…	**Good**	**Fair**	**Poor**
Before you answer, have you and your partners considered or addressed the following?			
Who are the key decision-makers and administrators for our organizations? Are they aware of our plans and do they support them, including the time we will spend on the project?			
Have we identified the resources needed from our organizations and received approval for them?			
Have we identified other organizations that will support our work and potentially contribute resources?			
Have we received positive responses and encouragement from our administrators to pursue planning an intervention?			

5. The amount of funding we have for planning and implementing the intervention is…	**Good**	**Fair**	**Poor**
Before you answer, have you and your partners considered or addressed the following?			
What funding do we have for planning an intervention?			
To implement and evaluate an intervention?			
Have we identified and/or applied for funding from other sources?			
6. The number of people we have to work on the intervention is…	**Good**	**Fair**	**Poor**
Before you answer, have you and your partners considered or addressed the following?			
How many individuals do we have to plan and implement the intervention?			
How much time can each individual spend? Will this change over time?			
Have we have defined roles and duties for individuals?			
Do we need individuals with special skills or expertise?			
7. The resources we have readily available to plan and implement the intervention are…	**Good**	**Fair**	**Poor**
Before you answer, have you and your partners considered or addressed the following?			
What are our space and equipment needs?			
What are our technology needs?			
Where can we find resources we might need out in the community?			
8. Our team's level of skills and expertise to plan and implement the intervention is…	**Good**	**Fair**	**Poor**
Before you answer, have you and your partners considered or addressed the following?			
What are the skills and expertise of our team?			

What training needs do our members have?			
What are our technical assistance needs?			
Will we need to bring in outside help (e.g., consultants or contractors)?			
9. The strength of our team's leadership is…	**Good**	**Fair**	**Poor**
Before you answer, have you and your partners considered or addressed the following?			
Who are the leaders of our team?			
Do the leaders motivate and support the team?			
Do we have shared leadership? How do we define leadership roles?			
Does our team respond favorably to the leaders?			
10. Our ability to work together as a team is…	**Good**	**Fair**	**Poor**
Before you answer, have you and your partners considered or addressed the following?			
Does our team communicate effectively?			
Do team members trust one another and work well together?			
Is our team organized and efficient?			
Does our team speak with a unified voice?			
What steps have we taken to incorporate team members in intervention process and activities?			
Do all of our team members actively contribute?			