

THE PREVENTION OF SUBSTANCE-EXPOSED PREGNANCIES COLLABORATIVE



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The Prevention of Substance-Exposed Pregnancies Collaborative (PSEP) represents 18 months of work led by CityMatCH with funding and guidance from the National Center on Birth Defects and Developmental Disabilities (NCBDDD), Centers for Disease Control and Prevention.

The six participating teams are to be commended for their significant efforts to prevent substance-exposed pregnancies.

- Sonoma County, California
- Multnomah County, Oregon
- Denver, Colorado
- Montgomery County, Ohio
- Florida Multi-County Team (Lead by Pinellas County)
- Baltimore, Maryland

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ABOUT CITYMATCH

City**MatCH** is a freestanding national membership organization of city and county health departments' maternal and child health (MCH) programs and leaders representing urban communities in the United States. The mission of City**MatCH** is to strengthen public health leaders and organizations to promote equity and improve the health of urban women, families and communities. City**MatCH**'s efforts are focused around three key goals in equity, science, and leadership, in order to strengthen and engage MCH leaders; advance health equity and social justice for improved family and community health; and promote the strategic use of data for the transformation of family and community health. Underlying these goals are the assumptions that the success of City**MatCH**'s work relies upon collaborations with our members and partners, and that we must validate the impact of City**MatCH**'s projects with a thorough and scientific evaluation of their outcomes.

This project follows City**MatCH**'s innovative Practice Collaborative model, in which City**MatCH** convenes, organizes and oversees an array of activities designed to educate, engage and support the local work of collaborative teams from select communities. In participating communities, local public health agencies form interdisciplinary teams of action-oriented leaders from a range of local institutions who combine their expertise and efforts to address a complex MCH challenge.

DEFINITIONS AND BACKGROUND

Alcohol, tobacco, and illicit drug exposures before and during pregnancy pose serious health risks for women of reproductive age and, if pregnant, to their unborn children.¹ Adverse outcomes include prematurity, low birthweight, birth defects and developmental disabilities, such as fetal alcohol spectrum disorders (FASD), and fetal demise. In 2006, the CDC/ATSDR Select Panel on Preconception Care identified smoking and alcohol use as 2 of the 14 preconception risk factors with effective interventions that should be addressed in clinical care during the preconception period.²

While most women attempt to discontinue substance use after learning they are pregnant, approximately half of all pregnancies are unplanned and women often do not realize they are pregnant until 4 to 6 weeks after conception. This period of continued consumption of alcohol and other harmful substances puts the developing baby at risk. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), in 2011:³

- 9.4% of pregnant women and 55.1% of non-pregnant women of childbearing age reported alcohol use;
- 17.6% of pregnant women and 25.4% of non-pregnant women of childbearing age reported tobacco use; and
- 5.0% of pregnant women and 10.8% of non-pregnant women of childbearing age reported using illicit drugs.

“Substance-exposed pregnancies” are defined here as those that include prenatal exposure to:

- *alcohol*
- *tobacco*
- *illicit drugs and/or prescription drugs (misused/abused)*

At-risk Alcohol and Other Substance Use:

- *Poses significant health risks to women of reproductive age, and for those who become pregnant, to the developing fetus*
- *One of the strongest predictors of substance use during pregnancy is substance use before pregnancy*
- *Early identification of substance use in the preconception period offers an opportunity to help women reduce major health risks, including risks to the developing fetus*
- *Evidence-based methods for screening and intervening on harmful use of alcohol, tobacco and illicit drugs have been developed and are recommended for use in primary care settings for women of reproductive age*

1 Floyd RL, Jack BW, Cefalo R, Atrash H, Mahoney J, Herron, A, Husten C, Sokol RJ. The clinical content of preconception care: Alcohol, tobacco, and illicit drug exposures. *American Journal of Obstetrics and Gynecology* 2008;199(6B):S333-S337.

2 Johnson K, Posner SF, Biermann J, Cordero JF, Atrash HK, Parker CS, Boulet S, Curtis MG, CDC/ATSDR Preconception Care Work Group, Select Panel on Preconception Care. Recommendations to improve preconception health and health care--United States. A report of the CDC/ATSDR Preconception Care Work Group and the Select Panel on Preconception Care. *MMWR Recomm Rep* 2006 Apr 21;55(RR-6):1-23.

3 Substance Abuse and Mental Health Services Administration, *Results from the 2011 National Survey on Drug Use and Health: Summary of National Findings*, NSDUH Series H-44, HHS Publication No. (SMA) 12-4713. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2012.

GOALS AND OBJECTIVES OF THE PSEP COLLABORATIVE

This multi-city, urban Collaborative focused on addressing alcohol and other substance misuse among women of reproductive age and preventing pregnancies that are exposed to alcohol and other substances.

This project built on the current work of CityMatCH member health departments and the expertise and experience of CityMatCH and NCBDDD.

Opportunities to prevent pregnancies exposed to alcohol and other substances are possible at many points of contact where women receive public and private health-related services. NCBDDD and CityMatCH applied the Practice Collaborative model in six urban communities to help identify effective, evidence-based practices and interventions at the local public health level to prevent pregnancies exposed to alcohol and other substances. Specifically, this Collaborative assisted with the development of strategies to screen and provide intervention services to women of reproductive age who may engage in risky use of alcohol and other substances. In order to accomplish this, CityMatCH and NCBDDD focused on two key areas:

- Education of providers (public health and health care) about screening and brief intervention (SBI), and
- Implementation of SBI in clinical settings serving women of reproductive age.

In the initial request for proposals, the four primary objectives of the Collaborative were (1) increase community knowledge and awareness of the risks of substance use before and during pregnancy; (2) decrease unintended pregnancies among women who use substances; (3) increase health care and social service provider knowledge and improving practices around substance use screening and brief intervention; and (4) increase public health department involvement in prevention activities. These overriding objectives were developed in response to an environmental scan of local health departments and their practices in the prevention of substance-exposed pregnancies. The environmental scan results indicated that there were a number of opportunities to increase community, health department, and clinical collaboration to reduce substance-exposed pregnancies and improve the capacity of local health departments in this specific area. It was the hope that each Collaborative team would incorporate these objectives into their local work and assess the progress in meeting these objectives through process and outcome measures.

Once the Collaborative was formed, the teams were asked to develop and implement a broad-based action plan to accomplish the following:

- Increase awareness and knowledge about the risks of alcohol use and other substances during pregnancy and its associated effects;
- Support changes in policies or procedures to promote the use

of SBI by health care providers and public health professionals serving women of reproductive age;

- Increase the number of settings (e.g., social service, reproductive health, behavioral health, primary care clinics) where women of reproductive age are screened for risky alcohol use and other substances as a routine part of care and services; and
- Increase the number of settings providing brief interventions as a routine part of care and services.

With time limitations and other challenges, not all teams were able to address all of these objectives. These goals were developed to provide parameters for the Collaborative's work and also offered a well-tested intervention model (screening, brief intervention, and referral to treatment) to build upon. It was equally important, however, that innovation in project design and implementation could occur among teams as needed based on their local priorities and expertise.

This publication details the experiences and lessons learned from the six teams, and it is designed to serve as a resource for communities interested in preventing substance-exposed pregnancies.

Reducing Substance Use during Pregnancy: What Works?

The Collaborative focused on increasing the awareness and knowledge among public health professionals, health care providers, as well as women of reproductive age about the risks of alcohol use and other substances during pregnancy and its associated effects. Work on reducing the specific risks of use was important because girls and young women have both increased and unique risks pertaining to alcohol, tobacco and drug use. In a National Center on Addiction and Substance Abuse (CASA) report⁴ females are at increased risk for:

- Greater impairment after drinking the same amount of alcohol (compared to males);
- Accelerated development of alcohol-related problems;
- Greater susceptibility to the development of alcohol-related medical disorders;
- Increased asthma attacks;

⁴ *The Formative Years: Pathways to Substance Abuse Among Girls and Young Women Ages 8-22*, The National Center on Addiction and Substance Abuse (CASA) at Columbia University, February 2003.

- Becoming addicted to nicotine at lower levels of use;
- Greater impairment of lung functioning;
- Greater difficulty quitting smoking;
- Greater likelihood of cocaine dependence;
- Greater susceptibility to brain damage from heavy use of Ecstasy; and
- Greater likelihood of hospitalization from nonmedical use of pain medications.

Females also have unique risks related to use of specific substances. For example:

- Alcohol use
 - Moderate to heavy alcohol consumption increases risk for breast cancer;
 - Heavy alcohol consumption increases risk for menstrual disorders;
 - Increases risk for female infertility;
 - Increases risk for an unplanned pregnancy; and
 - Increased risk for prenatal alcohol exposure.
- Smoking
 - Interferes with normal menstruation;
 - Increases risk of coronary heart disease in women who smoke and use oral contraceptives; and
 - Increases risk of breast cancer among women who begin smoking in early adolescence.

The Collaborative's main strategy to prevent substance-exposed pregnancies was substance use screening and brief intervention. This strategy was often supported by targeted provider training and education or other activities that emphasized the importance of identifying alcohol, tobacco, and other drug use as a major public health problem. Teams also worked to strengthen local support for prevention work in this area.

Screening consists of a validated set of questions to identify patients with possible substance use problems. Those patients identified 'at risk' are then provided a brief intervention where the provider discusses this behavior and works with the patient to increase their motivation to address the problem. These conversations can be very brief (5-15 minutes) or sometimes longer (multiple sessions) depending on the severity of the problem. Some patients may need more support or need referral to treatment providers. Screening and behavioral counseling for alcohol misuse and tobacco use

are recommended by the U.S. Preventive Services Task Force.⁵⁻⁶ Decades of research support the use of SBI in clinical practice for both tobacco and alcohol. While uptake of tobacco screening and brief intervention in primary care has increased (i.e., the “5 As”, an evidence-based smoking cessation counseling program that has been effective among pregnant and postpartum women), alcohol SBI has not yet been widely implemented in primary care settings. More work is needed to educate providers about talking to their patients about risky alcohol use and its related harms.

The epidemiology of the use and misuse of illicit drugs (i.e., any drug not used as intended) among women of reproductive age, particularly pregnant and post-partum women, is far from being well-described or understood. What little we do know suggests that illicit drug use is increasing and most prevalent among women in their prime reproductive years.⁷ Additionally, evidence regarding screening and brief intervention for illicit drug use is still considered insufficient.⁸ However, the American College of Obstetricians and Gynecologists does endorse the use of universal screening questions, brief interventions, and referral to treatment for OB/GYN patients related to illicit drug use.⁹ Best practices guidelines also are available through SAMHSA that recommend illicit drug use screening, brief intervention as needed and referral for treatment.¹

Prescription drug misuse has become increasingly problematic across the country and is having a devastating impact on maternal and infant health. Patrick et al., for example, examined the rates of maternal opiate use and [neonatal abstinence syndrome](#) per 1000 hospital births per year in the United States from 2000-2009.¹⁰ These researchers found that the incidence of antepartum maternal

Neonatal Abstinence Syndrome (NAS)
—a postnatal drug withdrawal syndrome of neonates—is used to describe the constellation of symptoms experienced by newborns withdrawing from substances on which they have become physically dependent while in utero. Exposure of the fetus to opiates, cocaine, amphetamines, or antidepressants may result in NAS; however, the most common causes are maternal opiate use (e.g., heroin, methadone) and misuse of prescription painkillers (e.g., oxycodone). The neonate also may be poly-drug exposed to illicit and licit drugs, nicotine, and alcohol. NAS usually manifests between 2-7 days following birth, depending on the amount and type of substances used by the mother during pregnancy.

5 Jonas DE, Garbutt JC, Amick HR, Brown JM, Brownley KA, et.al. Behavioral counseling after screening for alcohol misuse in primary care: a systematic review and meta-analysis for the U.S. Preventive Services Task Force. *Ann Intern Med.* 2012;157(9):645-54.

6 U.S. Preventive Services Task Force. Counseling and Interventions to Prevent Tobacco Use and Tobacco-Caused Disease in Adults and Pregnant Women: U.S. Preventive Services Task Force Reaffirmation Recommendation Statement. *Ann Intern Med* 2009;150:551-55.

7 Substance Abuse and Mental Health Services Administration, *Results from the 2010 National Survey on Drug Use and Health: Summary of National Findings*, NSDUH Series H-41, HHS Publication No. (SMA) 11-4658. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2011.

8 Lanier D, Lo S. Screening in primary care settings for illicit drug use: assessment of screening instruments - A supplemental evidence update for the U.S. Preventive Services Task Force. Evidence Synthesis No. 58, Part 2. AHRQ Publication No. 08-05108-EF-2. Rockville, MD, Agency for Healthcare Research and Quality, January 2008.

9 American College of Obstetricians and Gynecologists (ACOG) Committee on Ethics. ACOG committee opinion. No. 294. At-risk drinking and illicit drug use: ethical issues in obstetric and gynecologic practice. *Obstet Gynecol* 2004;103:1021-31.

10 Patrick et al. Neonatal Abstinence Syndrome and Associated Health Care Expenditures: United States, 2000-2009. *JAMA* 2012; 307(18):doi:10.1001/jama.2012.3951.

opiate use had increased from 1.2 to 5.6 per 1000 hospital births per year between 2000 and 2009. Furthermore, the incidence of neonatal abstinence syndrome had increased from 1.2 to 3.4 per 1000 hospital births per year between 2000 and 2009. Clinical interventions to help identify these problems early have not been adequately developed and tested; however, it is important for clinicians to recognize that prescription drug misuse, particularly opiates, as a serious problem that can affect their pregnant patients and the developing fetus. Both the American College of Obstetricians and Gynecologists and the American Academy of Pediatrics recognize the need to develop and implement clear guidance and practice guidelines;¹¹ however, many ethical and legal issues complicate the adoption of a universal screening tool.

Collaborative Process

Throughout the PSEP Collaborative, City**MatCH** provided the six teams with technical assistance, including tools for action planning and evaluation, informational calls, and resources to assist in carrying out selected strategies.

PSEP teams were composed of a core traveling team of 4-5 members who participated in all on-site meetings. In addition, each team had non-travel team members, which included a diverse group of individuals from within the community. Composition of the teams varied, with required members including MCH leadership from the local health department, and leadership from local community groups. Attention was paid to strengthening partnerships within these multi-disciplinary local teams to develop and implement innovative strategies for addressing substance-exposed pregnancies.

This collaborative was designed to drive action at three levels:

- *Level 1: Team-based activities for institutional and community change*
- *Level 2: Cross-team communication and collaboration, peer exchange and technical assistance*
- *Level 3: All-team collaborative activities to connect their work to work being done nationally, with the intent of improving overall urban MCH practice*

11 American Academy of Pediatrics. Substance use screening, brief intervention, and referral to treatment for pediatricians. *Pediatrics* 2011; e1330-e1340; doi:10.1542/peds.2011.1754.

American College of Obstetricians and Gynecologists. Methamphetamine abuse in women of reproductive age. ACOG Committee Opinion No. 470, March 2011.

American College of Obstetricians and Gynecologists. Opioid abuse, dependence, and addiction in pregnancy. ACOG Committee Opinion No. 524, May 2012.

Team-Building and Action Planning Exercises

Over 18 months, City**MatCH** and CDC staff assisted teams in furthering their understanding of substance use among women and evidence-based strategies for preventing substance-exposed pregnancies. With this enhanced understanding, teams were encouraged to develop strategies appropriate for their communities.

To provide a framework for the development and monitoring of these strategies, teams were led through a series of exercises called Tools, based on *Mapping Action Planning Strategies* (MAPS)¹² exercises. MAPS exercises are community-focused action planning exercises designed to provide a framework for building team cohesion and community action planning. The exercises were tailored to meet the changing needs of teams as they continuously refined their action plans.

The Tools include:

- **Tools 1 & 2 -- Assessing Systems and the Current Landscape**
- **Tool 3 -- Opportunities for Impact**
- **Tool 4 -- Action Planning for Change**
- **Tool 5 – Action Planning for Change, Part II**
- **Tool 6 – Evaluating Your Work**
- **Tool 7 -- Bulls-eye (Rapid Assessment) Activity**

Some of these tools were intended to help team members work together (e.g., Tools 1 and 2 assess systems and the current 'landscape' of the community addressing substance use issues), while others were deliverables that had to be completed and turned into City**MatCH** staff (e.g., Tool 4 Action Plan).

During the first PSEP on-site meeting in October 2011, Tools 1, 2 and 3 were used. These exercises helped teams assess the landscape of substance-exposed pregnancies in their communities and begin brainstorming potential strategies to pursue during the PSEP Collaborative. The remaining exercises assisted PSEP teams in reaching consensus on which strategies to pursue in their communities, making plans for carrying out the activities, implementing the activities, and monitoring their progress.

12 For more information about the MAPS exercises, see *Exercises for Team-Building and Community Action Planning: A Toolkit for MCH Leaders Addressing Racism's Impacts on Infant Mortality*. <http://webmedia.unmc.edu/Community/CityMatch/HealthEquity/TakingFirstStepSupplementBooklet.pdf>

WORK OF THE TEAMS

The following section presents profiles of each PSEP team. While this may provide only a snapshot of work conducted during the 18-month Collaborative, it demonstrates the teams' commitment and dedication to tackling the difficult issue of SEPs in order to improve maternal and child health outcomes. Efforts and strategies described in these profiles may be readily adapted in other communities throughout the United States and, hopefully, spark ideas for even more creative ways to address SEPs.

The six teams profiled on the following pages are:

- Sonoma County, California;
- Multnomah County, Oregon;
- Denver, Colorado;
- Montgomery County, Ohio;
- Florida Multi-County Team (Lead by Pinellas County)
- Baltimore, Maryland

Sonoma County, California

“Keys to our success were recruiting the right partners from the community and learning how team members wanted to communicate and work together. Being flexible was helpful, because it allowed us to respond nimbly to changes in staffing, budget and priorities.”

- Sonoma County Collaborative Team Member

Team Leadership -- Rebecca Jones Munger, CNM, PHN; Karen Clemmer, RN, PHN, MS

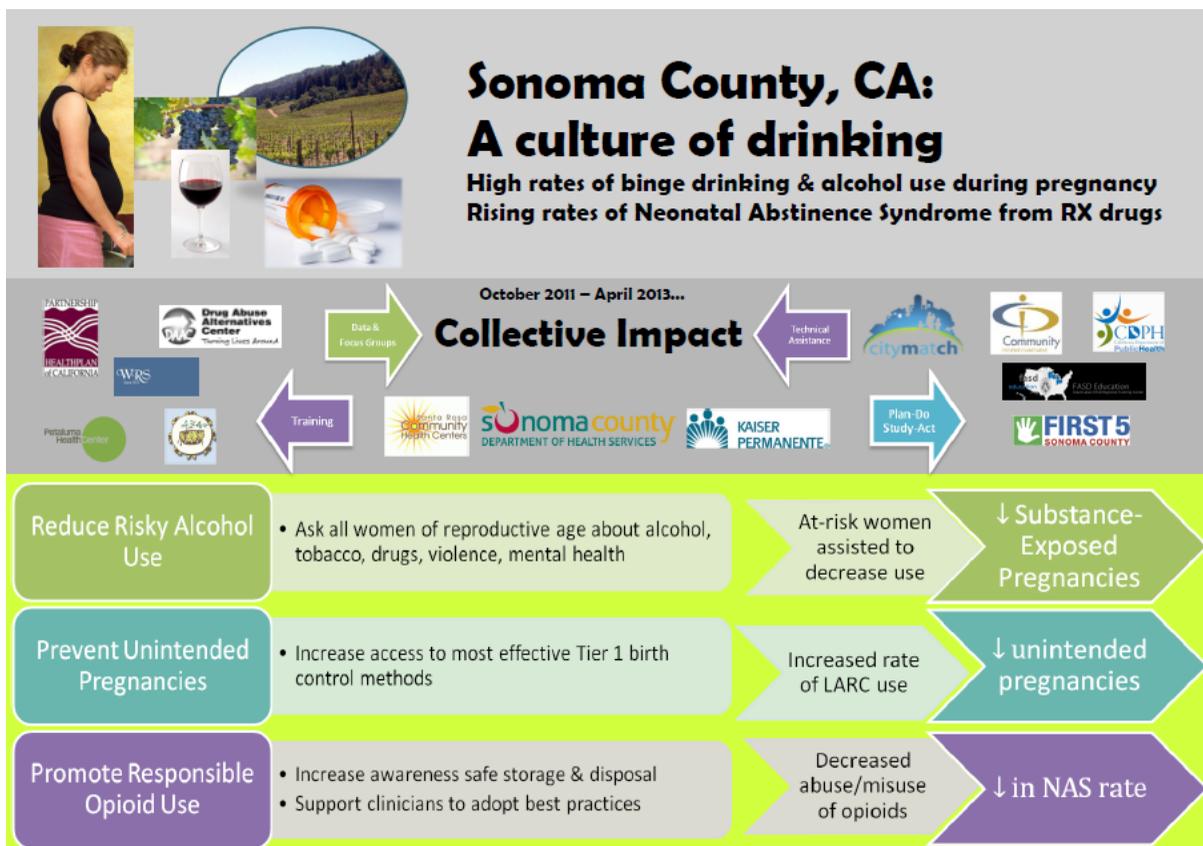
Additional Team Membership – Shelley Caviness; Adrienne Davis, MPH, CHES; Karla Fittipaldi; Debbie Hight, LCSW; Maria Jocson, MD, MPH, FAAP; Marshall Kubota, MD; Erin Lunde, MD, MPH; Erin Mallory, LCSW; Susan Milam-Miller, MD; Marie Mulligan, MD; Jess Oney; Lynn Scuri, MPH; Jennifer Silverstein, LCSW; Chandra Slavonic, MFT; Michael Spielman, MFT; Cheryle Stanley; Marlus Stewart; Gabrielle Trubach, MA; Teresa Voge, MPA; Laura Wong, Pharm D.

Overall Strategies/Focus

- **Strategy 1:** Implement screening for unhealthy use of alcohol, tobacco, marijuana, and prescription drugs among women of reproductive age in primary health care settings. Link this screening with tools to identify intimate partner violence and depressive disorders. Provide brief intervention and referral for positive screens.
- **Strategy 2:** Increase reproductive life planning and utilization of tier one contraceptive methods among women enrolled in the Family PACT program (Title X). Assist women of reproductive age at high risk of alcohol and drug use to reduce unintended pregnancies.
- **Strategy 3:** Increase the number of physicians and dentists that follow responsible prescribing practices for pain relievers and other addictive medications.

Local Picture

- Sonoma County is above the state median and state average for binge drinking in the 3 months before pregnancy and alcohol use during the 1st or 3rd trimesters according to the 2010 Maternal Infant Health Assessment survey.
- The California Statewide Home Visiting Needs Assessment published in 2010 shows Sonoma above the state median and average for non-medical use of pain relievers in the past year, and marijuana and other illicit drugs in the past months among persons 12 years and older.
- Non-fatal drug overdose emergency department visits, hospitalizations and death rates per 100,000 for Sonoma County are consistently higher than the California rate. Newborn hospital discharges with a diagnosis of neonatal abstinence syndrome for Sonoma County residents rose from 1.6 to 3.0 per 1,000 newborns between 2004-2006 and 2008-2010.
- By 11th grade Sonoma County teens are using alcohol at a rate higher than their peers across the state and the majority of high school students report that it is “very easy” or “fairly easy” to obtain alcohol from parents, older siblings, friends and retail outlets.
- 11th graders in Sonoma County have binge drink rates exceeding



the state average.

- A third of older students at the county's community college and a state university campus also report binge drinking.
- One quarter of cases reviewed by the Sonoma County Fetal Infant Mortality Review Team (2003- 2008) were associated with maternal substance use. While alcohol was the most common substance used, polydrug use was common. The majority of the women did not plan their pregnancies and over half had one or more previous therapeutic abortions.
- Use of highly effective contraceptive methods, such as Long Acting Reversible Contraception (LARC) methods by clients enrolled in the state Title X family planning program, are higher in Sonoma County compared to state wide but well below 10%.

Major Accomplishments

- A bundled screening tool for risky alcohol use, tobacco and other drugs, intimate partner violence and mental health concerns was piloted at three sites using the Plan-Do-Study-Act¹³ process. It is being integrated into the existing prenatal screening program and used to screen all women of reproductive age.
- Over 50 clinicians have been trained to provide LARCs. This has expanded the capacity for women to easily access dependable birth control to prevent unintended pregnancies. A reproductive life planning curriculum is ready for implementation within a local perinatal alcohol and drug treatment program.
- There is increasing awareness about the impact of prescription drug misuse and abuse on pregnant women among medical providers and other maternal-child health advocates. For example, an article was published in the local medical association journal, a half-day professional training was attended by 60 clinicians, more local prescribers are now registered to use California's Prescription Drug Monitoring Program (CURES), and Safe Kids Sonoma County is promoting safe disposal with parents.

Major Challenges

- Balancing the "right" level of engagement with our partners so they don't "burn out".
- Collaborating with the clinical sites to ensure leadership buy-in and adoption of organizational policies.
- Addressing unanticipated issues unrelated to the work but heavily impacting progress.

13 <http://www.ihl.org/knowledge/Pages/HowtoImprove/ScienceofImprovementTestingChanges.aspx>

- Finding Spanish-language materials and translation services.

Discoveries

- It is possible to bring together community members with diverse backgrounds to work on a common goal.
- The level of interest and momentum of the prescription drug workgroup was unexpected and allowed the group to accomplish results in a short period of time.
- Clinical staff need training and coaching to understand the concept of “risky drinking” behavior.
- There are practices which significantly increased the use of Tier 1 contraception among women wanting to prevent pregnancy.
- Mental health concerns are common among women of reproductive age and more resources are needed to adequately address the need.
- Forms and materials must be kept simple and work with the electronic medical record.
- Testing materials and clinic flow before scaling up is essential.

Impacts of Participation

- City**MatCH** brought credibility and timeliness to the practice collaborative, making it easier to recruit and retain partners.
- What team members learned in the collaborative shifted our focus to work on “risky” or unhealthy drinking instead of dependent drinking and improved our ability to deliver a clear message about alcohol use during pregnancy.
- Technical assistance calls increased our understanding of the interrelationship between behavioral health and substance use among women of reproductive age.
- Participation in the collaborative provided new partners from other communities working on the same issues (e.g., Denver and St. Louis).

Intended Long Term Impact

- New partnerships were developed between community health centers, alcohol and drug treatment providers and the managed care organization, Medi-Cal (California’s Medicaid program).
- A shared understanding of the role of Adverse Childhood Experiences¹⁴ and a vision for how to improve maternal and child health.

Work Ahead

- Continue *Plan-Do-Study-Act* cycles with partners implementing the Women's Health Questionnaire.
- Embed the screening tool into the electronic medical record systems.
- Use the integrated screening tool in place of the existing prenatal alcohol and other drug screening tool at health centers throughout the county.
- Recruit other health centers to begin screening all women of reproductive age.
- Expand availability of services that address behavioral health needs identified in the SBI.
- Introduce questions about contraceptive use into the intake assessment for clients entering alcohol and drug treatment programs.
- Continue to build capacity to provide Tier 1 birth control methods within the health centers so that women at risk for substance-exposed pregnancies will use highly effective contraception.
- Pilot *Reproductive Life Planning* curriculum at the perinatal treatment program and adapt it for multiple audiences.
- Support policy work on prescription drug dispensing and disposal.
- Provide technical assistance to at least one health center to implement best practices for prescribing, storing and disposing of controlled substances.

Multnomah County, Oregon

“Some assets key to our success: strong native organizations; passion for and commitment to the project; partners with the ability to “code switch”; safe space for honest conversations; recognition of the importance of language. [It is also important to take] the time for ... relationship building and using trauma informed planning process in other communities and document results.”

- Multnomah County Collaborative Team Member

Team Leadership – Heather Heater, MPH; Sarah Tran, MPH

Additional Team Membership – Charmaine Kinney, MPA-HA; Terry Ellis, LCSW

Project Description

The Future Generations Collaborative is a cooperative circle of Native-serving organizations, Native community members, state and local public health agencies, and community based organizations who are committed to promoting healthy pregnancies and healthy babies in Multnomah County's Native community. Together we will increase the number of healthy births and improve the health of future generations.

The project has four phases: 1) information gathering through community forums; 2) community validation of the results; 3) community action planning; and 4) dissemination of the action plan and organization of community commitments.

Overall Strategies/Focus

Capacity Building: Focus on community capacity building and collective problem solving, with an emphasis on creating population-level policy and community-level approaches to ensuring the health of generations.

Coalition Development for Collective Impact: Using a trauma-informed community-based participatory planning (CBPP) process (See Appendix A, Multnomah), we use culturally relevant approaches to engaging partners and the community. The trauma-informed process guides implementation of a health assessment of knowledge, attitudes, and practices around substance use and preconception health among urban American Indian/Alaskan Native (AI/AN) populations. The information will inform the development of a community action plan that will be grounded in the experiences of, and solutions identified by, urban Native peoples.

Local Picture

- Over 400 represented tribes in Multnomah County; 1 in 3 Natives are under age 18. There are 28 Native-serving organizations in Multnomah County. This is a strong, resilient community.
- 57% percent of American Indians/Alaskan Natives in Multnomah County consumed alcohol regularly during the three months before pregnancy -- this rate is the second highest of all racial/ethnic groups measured.
- American Indian/Alaskan Native women have one of the highest rates of smoking before pregnancy (40%) and one of the highest rates of smoking during pregnancy (20%).
- The teen pregnancy and birth rates are also elevated among American Indian/Alaskan Native youth compared to other demographic groups. During 2005-2007, 44.8% of births among American Indians and Alaskan Natives in the County were to mothers aged 15-24; this rate was second only to the African American rate of 48.3% and considerably higher than the county-wide rate of 28.1%.
- Over half of the live births to American Indians/Alaskan Natives in Multnomah County were from an unintended pregnancy, compared to 40% of live births county-wide.
- Low birth weight prevalence among babies born to American Indian/Alaskan Native women has doubled since 1997, growing from 3% in 1997 to about 6% in 2007. In contrast, low birth weight prevalence for all other racial/ethnic groups has remained relatively stable over the ten year period.

FGC

Future Generations Collaborative

Members of the FGC have committed to addressing substance exposed pregnancies among American Indian/Alaskan Native women in our county.



THE PROBLEM



More than 1 in 2 AI/AN women drank alcohol in the three months prior to pregnancy



1 in 5 AI/AN women smoked tobacco during pregnancy-- 10x the Healthy People 2020 goal

THE CONTRIBUTORS

Poverty



36% of AI/AN in Multnomah County experience poverty compared to 15% county-wide

Unintended Pregnancy



Over 50% of births to AI/AN are unintended

Intimate Partner Violence



Over 6% of AI/AN women who gave birth in 2009-2010 reported IPV before or during pregnancy

As a result of better understanding of the root causes AI/AN health, the collaborative morphed into a trauma-informed process

TRAUMA INFORMED PROCESS

Values	Community
Culture	Relationships

Our trauma-informed process is guided by a relational world view model in which all domains need to be in balance to find health and healing (left). Using this approach has built a successful collaborative with Native representation and participation

Native Participation

First Meeting

15%

Most recent meeting

56%

NEXT STEPS

A



B



C



A

Community Forums

B

Data Validation

C

Action Planning

- In 2007, 10.5% of live births among American Indians/Alaskan Natives were pre-term (the second-highest rate of all racial/ethnic groups measured), and 13% of infants born to American Indian/Alaskan Native mothers required time in the neonatal intensive care unit (the highest rate of all groups measured).
- Between 2003 and 2007, the infant mortality rate among American Indians/Alaskan Natives was 9.0 infant deaths per 1,000 live births, equaling a disparity ratio of 1.8 compared to the rate for White non-Hispanics of 5.1 infant deaths per 1,000 live births.

Major Accomplishments

- Developed and implemented a trauma-informed process
- Adopted a relational worldview to inform our practice
- Created a community-based participatory planning process
- Effectively addressed issues of mistrust to increase and sustain Native participation in the collaborative; Renamed group as Future Generations Collaborative (FGC)
- Community member designed logo
- Successfully recruited and trained 18 community members as community organizers and process facilitators
- Fiscal and in-kind donation from Multnomah County Health Department
- Partners committed a full-time employee to the project
- With grant and general fund, hired two staff members – highly respected members of the Native community
- Received \$50,000 capacity-building grant

Major Challenges

- Bureaucratic barriers
- Lack of money
- Lack of dedicated staff time for project management and coordination
- Grant application to Tribal organization rejected
- Native partners having to “code switch”¹⁵
- Legacy of historical and intergenerational trauma:

¹⁵ Code switch: The practice of moving back and forth between two or more languages or varieties of language in conversation. http://oxforddictionaries.com/us/definition/american_english/code-switching

- Relationships between partner agencies strained
- Deep mistrust of government agencies and public health
- Persistent health inequities among Native people – can feel overwhelming to tackle any one issue

Discoveries

- Need to invest a significant amount of time in partnership development and trust building
- Developing the model and naming the process “trauma informed planning process”
- The potential to become a best-practice model for culturally relevant community engagement at a regional, state and national level is high
- Developing personal and professional supports for maternal and child health
- The government entity has to be flexible and be able to use a community development framework to meet the communities readiness and needs
- Must be able to use active listening skills
- Get support from our funding source and leaders to be flexible
- Community healing is essential for moving past causes to the development of solutions
- Using traditional approaches for a modern day problem

Impacts of Participation

The PSEP Collaborative served as a catalyst for organizational change, community engagement, the development of new partnerships, and to some degree, community healing. The opportunity shone a spotlight on institutional practices that were contributing to poor health outcomes among AI/AN community members by illuminating ineffective but ingrained public health approaches that were contributing to a divisive environment where partnerships were unable to flourish. As a result of the PSEP, a trauma-informed process was developed and stakeholders (e.g., state and local health departments, Native community members, and Native-serving organizations) are much better equipped to address root causes of health inequities and disparities, including substance-exposed pregnancies.

Without this opportunity, incredible progress may not have happened at all. Despite consistent data showing that the economic well-being and health of urban Natives consistently fared worse than most racial/ethnic groups in Multnomah County, the local health department did not have

programs or plans in place to correct the inequities. Multnomah's PSEP Collaborative team has developed a trauma-informed process that became central to their success of developing a culturally-relevant community participatory process with Native stakeholders. Without this foundational work, it is likely that the practices that perpetuated ill-will and prevented effective partnerships from forming would have continued as the primary way in which the local health department attempted to engage the Native community.

Receiving the CityMatCH/CDC funded grant proved a stepping-stone for attention and accolades from additional funders. Being recognized by two prestigious public health organizations ensured that the project was seen as valid in the eyes of public health and (non-Native) governmental organizations.

The robust collaborative would not be successful without the kindred spirits who are working respectfully together to learn, grow and change in order to create a brighter, healthier future for Native women, children and families.

Intended Long Term Impacts

Systems and organizational change:

- Government agencies will incorporate a relational worldview into their practices to more effectively partner with Native stakeholders.
- Government agencies can begin to regain trust and credibility in the Native community, opening doors to better utilization of health services and more effective collaborations.
- Individuals and organizations within the Future Generations Collaborative (FGC) will feel comfortable accessing public health infrastructure supports for future capacity building and health promotion efforts.
- Organizations and community members will invest in ongoing partnerships to achieve community-identified strategies.
- Other health departments interested in adopting the process as a model for partnership and community-based participatory planning will receive technical assistance.

Improving the health of communities:

- Community members will be better equipped to identify, plan and address health inequities.
- Social and cultural norms will support healthy pregnancy planning and abstinence from substances before, during and after pregnancy and while breastfeeding.
- Reduction in number of substance-exposed pregnancies.

- Improved birth outcomes.
- Healthier children, healthier families, healthier communities.

Work Ahead

- Increase circle of influence of Native-serving organizations and Native community members.
- Increase representation of hidden voices in the community.
- Increase funding to sustain collaborative efforts.
- Implement culturally-specific, practice-based evidence (vs. evidence-based practice).
- Listen to community stories about healthy pregnancies.
- Plan community actions.
- Organize community commitments.

The FGC is taking a long-term approach to this effort, recognizing that building trust and strengthening partnerships are essential to reducing health inequities. Community forums provided localized data on attitudes, knowledge and behaviors regarding healthy pregnancy planning and how culture contributes to good birth outcomes. Additionally, the FGC aims to increase hidden voices in the community, elevate the priority of addressing health inequities of Native community and build on current skills and knowledge to increase the capacity of the local Native community to engage in health promotion planning.

Denver, Colorado

“We recommend just getting into action. Progress is easier than you might expect and building a plan interactively has worked for us.”

- Denver Collaborative Team Member

Team Leadership – Kellie Teter, MPA; Karen Petersen, MD

Additional Team Membership – Grace Alfonsi, MD; Pamela Gillen, ND, RN, CACIII

Overall Strategies

The goal of the Collaborative is to standardize screening for alcohol and contraceptive use in women of reproductive age and to coordinate intervention resources throughout Denver Health as a model that could be spread to other health systems.

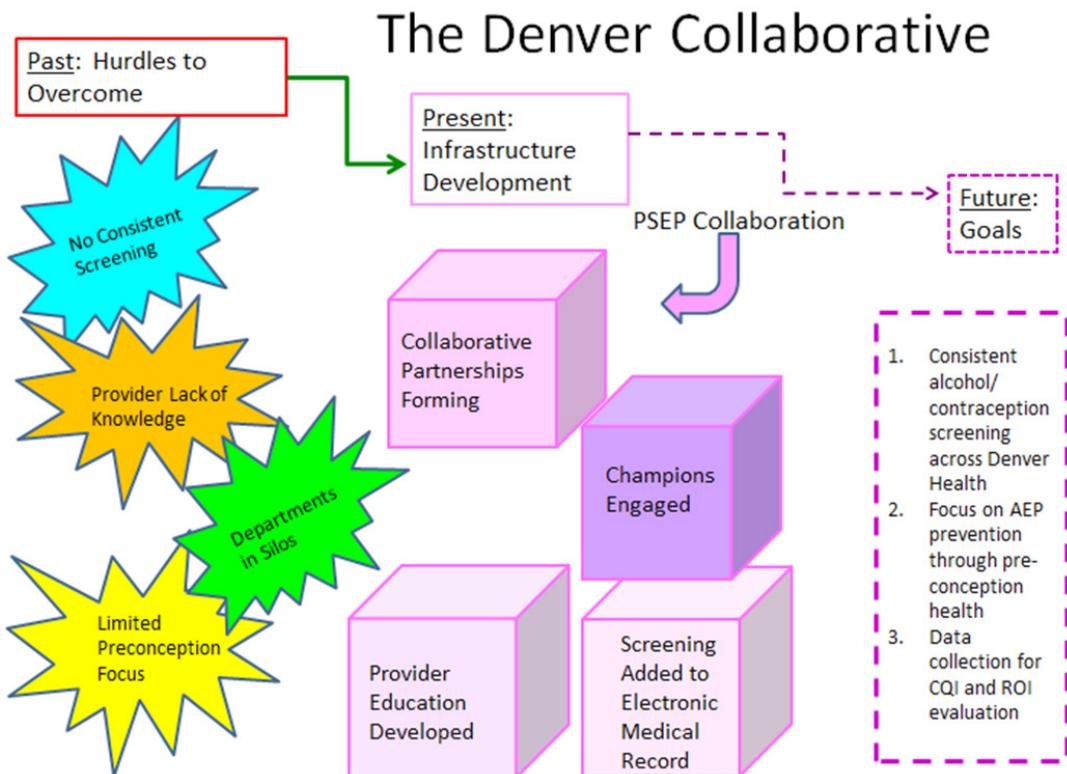
Our strategy is to demonstrate universal screening, brief advice and brief intervention for all appropriate clients in the Denver Metro Health Clinic. Steps include:

- Set up training of staff (using mini-modules and SBIRT reimbursement guidelines)
- Provide training on and support clinic flow for new services
- Implement model screening and intervention for alcohol-exposed pregnancies (AEP)
- Explore billing for these services
- Study new clinic flow and data collection from new services
- Select improvements and re-train if necessary

Performance will be measured by the percentage of eligible clients getting services, as documented in the clinic’s electronic health record system.

Local Picture

- Denver Health and Hospital Authority (Denver Health) is the largest safety net health care system in Colorado. Through its Community Health Services, Denver Health provides primary care (medical, dental and mental health) to about 20% of adults and 35% of children residing in Denver County. Over 3,500 deliveries occur yearly at Denver Health.
- Denver Health and Denver Public Health operates within numerous silos and work is being done which can help lower the risk for AEP in several areas, but is not effectively coordinated across the system.
- 2009 PRAMS data showed that 11.7% of Denver women drank alcohol during the last 3 months of pregnancy.
- BRFSS data from 2009-2010 showed that in the past 30 days, 15.6% of Denver women reported binge drinking in the past 30 days (compared to 11.0% in Colorado as whole).
- The 2008 PRAMS data shows that for Colorado, 57.7% of women drank during the three months before pregnancy and 10.7% drank during the last three months of pregnancy.
- The 2008 PRAMS showed that among women under 20 years of age, 66.3% of pregnancies were unintended. The 2008 YRBS data, which captures part of this group, showed a high rate of alcohol



use and lack of contraception in high school females in Colorado: 77.3% reported ≥ 1 lifetime drink; 44.2% reported ≥ 1 drink in last 30 days; and 27.2% reported ≥ 5 drinks on an occasion in last 30 days.

- Data from the Denver Metro Health clinic (DMHC), and the DPH STD clinic, indicate that women < 44 years of age have high rates of both binge and heavy drinking, coupled with high rates of ineffective contraception. Since October 2010, 3,284 women < 44 years of age have been screened in the clinic; 34.2% report binge drinking, 19.6% heavy drinking, and 18.5% both binge and heavy drinking. Those groups have corresponding ineffective contraception rates of 59.5%, 60.4% and 59.6%, respectively.

Major Accomplishments

Added Screening Questions in the Electronic Medical Record (EMR):

- Denver Health is adopting a new EMR.
- The team was able to identify and influence key participants in the EMR process to ensure alcohol, drug and tobacco screening would be mandatory components of the EMR.
- Screening, Brief Intervention, and Referral to Treatment (SBIRT) questions formed the backbone of these sections.
- Contraceptive questions are still in progress but will be detailed since the Community Health Services sites are Title X sites.
- EMR rollout has been suspended for Ambulatory (clinics) and a new strategy has been developed.

Educational Modules:

- First education modules were delivered in December 2012 beginning with Pediatrics, Family Medicine, and OB/GYN departments of Denver Health.
- A total of 10 educational mini-modules (10 minutes in length) will be available in 2013 in clinic settings across the DH system and in the Denver provider community.
- Team educators will negotiate with the clinics about how much time is available and which topics are most important for their staff.
- Topics include:
 - Summary Module (1 or 2 slides from each topic)
 - How much is too much?
 - Why is too much alcohol bad news?
 - Fetal development and substance use
 - Use vs. Abuse vs. Dependence
 - Techniques to cut down and/or quit alcohol use

- Youth health and substance use
- Marijuana information and side effects

Major Challenges

Carving out time to work on the project has been a challenge. Barriers and challenges will occur so it is important to have champions and cheerleaders on your team.

Discoveries

- It was easier than expected to build support for the project.
- The implementation is the key step.
- To achieve consistent, quality, universal screening and short intervention may prove highly challenging over time.
- The team has been able to elevate alcohol as a public health priority, and this was unexpected.

Impacts of Participation

- The team was regularly inspired by the work of the other teams. They especially helped to appreciate a realistic time line for building the work (this may take years!), and to expand ideas about partners (WIC, Kaiser, insurance payers.)
- Internally the joint effort of a Clinic Provider and a Health Promotion Manager has opened the door to other clinical-population health collaborations in the department. Finally, the extent to which this work served to elevate alcohol as a public health priority, was unexpected.

Intended Long Term Impacts

- Universally collected data on alcohol use among our clinics' patients' will provide information to improve preconception health on an ongoing basis. With the data as a currency, and a "return on investment" case in hand, the team can more easily leverage resources toward more and more consistent screening. The team believes that AEP is costly and well worth the investment of prevention resources, but data is needed to compel the system to make resource allocations.
- Implementation of the Electronic Medical Record in the clinics is suspended indefinitely. It remains to be seen if the team's momentum is sufficient to carry them "over" that hurdle. They are continuing to explore how, in the absence of the EMR, they can create screening (and maybe even data collection) as standard work.

Work Ahead

- AEP is now a formal aspect of the preconception health project in Denver. Title V funds will continue to support this work as the team provides more training, collaborates with STD CHOICES, innovates the delivering of true SBIRT and short interventions of other kinds throughout the clinical and prevention system.
- Making alcohol screening “standard work” at every encounter in the health system (as they have endeavored to do with tobacco use) is the team’s goal. A new committee has been formed with leadership from across Denver Health departments to engage in the training, record keeping and administrative aspects of this change. This standardization and the quality improvement (QI) to keep this working is a major long-term effort.
- The team has the support of the administrative director and is close on their goal of securing additional champions inside their sister department, Community Health (all outpatient services). The inpatient side remains but in some ways is easier due to increased level of standardization in the hospital in general.

Montgomery County, Ohio

“We recommend having a goal/vision/purpose at the start of the project will give the new coalition energy and direction to begin. Bring all key people and stakeholders to the table and reevaluate this list at least yearly to see if a new initiative/project/direction necessitates the inclusion of others. Small committees with specific purposes/assignments can move faster than utilizing the entire coalition to move a project further.”

- Montgomery County Collaborative Team Member

Team Leadership – Sara Paton, PhD; Tracey Waller, MBA, RD, LD

Additional Team Membership – Julie Dversdall, MS, RN, CPNP; Susan Caperna; Andrea Hoff, MPA, GPC, OCPS II, ICPS; Beatrice Harris, MS, RN

Overall Strategies

The Dayton PSEP Team is organized by the Montgomery County FASD Task Force, a focused collaborative entity that reaches beyond normally established systemic boundaries, which increases its ability to influence policy changes. The Task Force oversees a measured examination of the gaps in our current community system through the development of a needs assessment, provides a format for collaborative community planning, and coordinates the development of a county-wide comprehensive strategic plan, including the expansion of screening efforts throughout Montgomery County.

The intention around this community plan is long-term, sustained efforts that will impact Montgomery County residents on a large scale. Underlying all of this is the ultimate benefit for the community: Pregnant women choosing to abstain from drinking alcohol and, as a result, giving birth to healthy babies.

Local Picture

- Montgomery County has a disproportionately high number of substance abuse referrals. In 2008, Montgomery County referrals were approximately 12% of all referrals in the state while the population of Montgomery County makes up approximately 4.7% of the state's population.
- The average drug mortality rate per 100,000 (1999-2006) was substantially higher for Montgomery County (20.8) versus for Ohio as a whole (10.3). The average alcohol mortality rate per 100,000 (1999-2006) in Montgomery County is also higher than for Ohio as a whole, averaging 19.5 vs. 13.5.



- Infant mortality rate for Montgomery County in 2010 was 7.4 per 1,000. For African Americans, it was 14.2 per 100 and for Whites it was 5.4 per 1,000.
- 9.5% of births were low birthweight (LBW) in Montgomery County in 2010.
- 13.0% of mothers of LBW babies indicated that they drank during pregnancy and 13.7% reported drug use during pregnancy in Montgomery County.
- 42% of Montgomery County pregnant women access WIC services during their pregnancies and 63% of infants receive WIC services at some point during the first year of life.
- 50% of pregnancies in Montgomery County are unintended, according to 2006-2007 PRAMS data.

Major Accomplishments

- Implementation of alcohol screening and brief intervention (ASBI) into primary care
 - Identification of where and who (working on the how and when).
 - Task Force will provide technical assistance to integrate the ASBI.
 - Partnership with Kettering Health Network will provide training and coaching to the staff.
 - Using trainers who are “MINT” Certified. the gold standard in Motivational Interviewing training.
 - Introduction of ASBI within a federally qualified health center.
- Completion of the SAMHSA subcontract for ASBI in the WIC clinics and subsequent transition to permanent ASBI model.
- Multiple community education events, including grand rounds and other presentations.
- Developed and implemented a pilot program within the business community. The team has partnered with the area Chamber of Commerce to implement a Screening and Brief Intervention program whereby individuals who are unable to pass the drug screen will be sent to an employee assistance program (EAP) to receive a brief intervention. This new program has the ability to impact a significant portion of the business community and to prevent individuals from continuing down the path of drug misuse, abuse, and potential addiction.
- Reallocated funding to run another large media campaign (during an appropriate time of year) and buy multiple copies of FASD

literature to provide to community agencies.

- Work with Parents
 - A networking group of parents, caregivers, professionals, and others working with FASD individuals, meets monthly and is facilitated by a Task Force member.
 - Triumph Through the Challenges of Fetal Alcohol Spectrum Disorders is offered quarterly. It is a proven curriculum that examines characteristics of FASD, strategies for addressing a child's inappropriate behavior, coping skills for parents, and much more.
- Multiple prestigious awards received by team members for their work in this area.

Major Challenges

- Time away from primary paid position; all but one Task Force member is voluntary.
- Staff issues -- unexpected turnover during project stalled progress.
- Timing for selected implementation site wasn't right -- had to wait for them to be ready.
- Lack of funding for training.
- Networking -- knowing the right person to approach to advance team goals, and developing the "right" approach.
- Funding was a challenge because the team actually secured ample funding for the year and then had difficulties expending the funds because of the unexpected turnover.

Discoveries

- Patience -- things can't and won't happen quickly.
- Perseverance -- continuing to be available for questions and open to variations on the original plan.
- Barriers are workable -- keep looking for solutions and alternatives.
- Need for consistency in who is involved -- turnover in key positions can stall a project. Have a succession plan in place.

Impacts of Participation

There was a definite renewed momentum over the last year. The tools and data that the team had access to gave the Task Force new directions to explore. Individuals have benefited from the resources, meetings, and website in making individual presentations to their agencies, and to many community groups. Connecting with others around the country and expanding individual perspectives about the challenges of substance-

exposed pregnancies and the interrelation among other community issues was very eye-opening.

Intended Long Term Impacts

- If the State WIC program fully implements ASBI in all WIC clinics in Ohio, there is the potential to screen 4,500 pregnant women per month, or at least 50,000 per year. This effort will be seen by other states as a “do-able” objective and can be implemented beyond Ohio.
- Because ASBI has become the accepted standard of care for detecting, educating, and decreasing alcohol misuse, they hope to see that providers/community programs are all talking the same language—so recipients of care are hearing the same message from everyone they interact with.
- Completing the implementation of ASBI into the Five Rivers Health Centers will enable the team to seek out more primary care sites to approach.
- As the Training the Trainer program expands across the region, they will see a very educated community; again, a community that is speaking the same message.
- With the business community in the area gearing up to pilot the SBIRT initiative, the team expects to collect data and potentially expand into other communities if the effort is successful.

Work Ahead

- The biggest goal is to continue to implement the strategic plan and make these efforts become the norm in their community and self-sustaining.
- Continue to model ASBI in Montgomery County WIC offices as a standard of care.
- Provide support and technical assistance to Five Rivers Health Centers to integrate ASBI into their practice.
- Dayton Children’s Medical Center via contract with Public Health will continue to advance the strategic plan.
 - Collaborating with curriculum directors at Wright State University, University of Dayton, and Sinclair Community College to implement FASD curriculum developed by CDC.
 - Promoting FASD Prevention Toolkit for Women’s Health Care Providers (developed by ACOG and CDC).
 - Offering a motivational interviewing workshop to hospital staff, utilizing local Mint-certified trainers.
- Expand representation on the Task Force to include additional

pertinent agencies.

- Work with ODH State WIC office to bring ASBI to WIC programs in more counties.
- Discuss conversion from “Task Force” to “Coalition.”
- Bring the Kentucky “Train the Trainer” program to Montgomery County in early 2013.
- Present the project at a national conference and submit a publication.
- Pilot SBIRT in the business community for employers and prospective employees.
- Begin the process of creating a training webinar to train all WIC health professionals in the ASBI process so that multiple WIC sites can replicate Montgomery County’s success.
- Move forward with implementing ASBI in primary care at one site and work through the process to add sites in the future. With the US Preventative Services Task Force guidelines that were recently published, the team is prepared to assist any interested primary care office in the area with implementing ASBI in their offices.

Florida Multi-County Team (with leadership by Pinellas County)

“We need to focus on the mother and baby holistically, as a unit. The attitudes and beliefs of professionals related to substance abusing moms must be non-judgmental. If the mother is criminalized, it will not improve the outcome for the mother and baby. We must be careful not to label and criminalize.”

- Florida Multi-County Collaborative Team Member

Team Leadership – Christine Gibson, CAP; Judi Vitucci, ARNP, PhD

Additional Team Membership – Kay Doughty, MS, CAP, CPP; Jane Murphy, MSW; Lori Reeves, MPH; Dixie Morgese; William Sappenfield MD, MPH; Kris-Tena Albers; Carol Scoggins, MS; Rhonda Brown; Mari Detres, MA; Jane Bambace; and Jennifer Highland.

Overall Strategies

- Establish effective statewide PSEP Collaborative.
- Work with physicians and providers serving on March of Dimes workgroups to develop at least one clinical guideline or protocol for screening and brief interventions for pregnant women and infants.
- Identify and adapt or develop at least one clinical guideline or protocol for treatment of pregnant women and newborns by obstetricians, neonatologists and pediatricians, including protocols/best or promising practices for:
 - Treating opioid-affected newborns,
 - Treating pregnant women using opioids, and
 - Treating and the mothers of opioid-affected newborns
- Design and implement at least two provider non-clinical education programs.
- Pilot provider screening tools in multiple Florida counties.
- Recommend to the Redesign Committee that Healthy Start implement screening and brief intervention statewide.
- Develop educational programs for Child Protective Investigations and probation offers.
- Development of algorithm for positive screens.

Local Picture

- According to 2009 Florida Behavioral Risk Factors (FBRF) data, 12.4% of adult females in Florida engaged in heavy or binge drinking and 13.2% in Pinellas County. In the 2010 FBRF, 8.2% of adult females in Pinellas and 10.5% in Florida engaged in heavy or binge drinking.
- 2002 Florida PRAMS data show that 5% of women consumed alcohol during their most recent pregnancy. There is no data for alcohol in the 2010 PRAMS data.
- In 2009-10, of women who consented to prenatal Healthy Start screening, 14,539 reported alcohol use in Florida, and 715 reported alcohol use in Pinellas County (Healthy Start Prenatal Screening report).
- According to the Substance Abuse Prevention Coalition, illegal use of prescription pain medication is increasing in Florida. From 2005-2010 there was a 433% increase in newborns treated in Florida hospitals for drug withdrawal symptoms, according to the Agency for Health Care Administration (AHCA). A Florida News Press (12/20/2010) review of Florida discharge records showed that Neonatal Abstinence Syndrome from all types of drugs has almost tripled since 2005. In 2011, 2019 Florida newborns were diagnosed with Neonatal Abstinence Syndrome (NAS) -- a rate of 9.47 per 1000.
- Despite a statewide focus on keeping families intact, in 2010 Pinellas had more out-of-home placements for children than any other area of the state. According to DCF, the majority (57%) of these child removals were due to drug misuse. In September 2010, 52% (39/75) children were removed from their homes in Pinellas by child welfare due to substance abuse at a cost of \$237,600 for 12 months. In November 2012, 11% (8/67) child welfare removals were due to substance abuse at a cost of \$198,000 for 12 months.
- According to the Department of Children and Families (DCF 2008), Pinellas has the highest newborn withdrawal rate (70/1000) in the state and that rate has increased significantly since 2005.
- Operation PAR, a drug treatment center in Pinellas, reported that roughly 85% of the 2899 drug abusers in methadone treatment are there because of pain pill use.
- U.S. Drug Enforcement Agency (DEA) data show 126 million pills were dispensed through Florida pharmacies in 2010. By far, more Oxycodone is dispensed in the state of Florida than in the rest of the nation combined, according to testimony to the US House of Representatives on April 14, 2011 by Governor Rick Scott.

Major Accomplishments

- PSEP expanded to participants in other areas and PSEP resources & learning opportunities were shared statewide.
- Extensive collaboration state-wide with increased buy-in at the local and state level with six local substance-exposed newborn task groups established in various parts of the state.
- A new program for screening and brief intervention for substance misusing new mothers (MOMS) was established by a drug treatment center.
- Two MD practices implemented the 5 P's Behavioral Risk Screening tool. The pilot sites determined that they identified more substance using women using the 5 Ps than the previous screening method.
- With legislative advocacy, two PSEP members were included in the State Attorney General's Statewide Prescription Drug Task Force.
- 2589 individuals were trained on prescription drugs in pregnancy and techniques for working with substance-exposed newborns.
- 209 home visiting staff were trained in motivational interviewing.
- A wallet card of questions for consumers was developed and disseminated statewide in December 2012.
- Local Substance-Exposed Newborn Task Force Workgroups formed to address the issues at the local level.
- Conferences/Summits held:
 - Funding obtained from March of Dimes and Hillsborough Children's Board to train MDs and other direct service providers at a State Drug Summit in December 2012
 - Generation RX conference with 171 attendees held in October 2012
- Webcasts provided:
 - Webinar with Dr. Ted Parran for Florida physicians and other providers in April 2012.
 - Drug Awareness Webcast by Florida Department of Health and Florida Medical Association held in March 2012.

Major Challenges

- Drug treatment contracting changed at the state level and limited treatment options for pregnant women.
- Time constraints and rules for community involvement within participating agencies have changed.
- Changes in leadership on state level with four key team members lost.

- Substance abuse screening question previously removed from statewide universal risk screening of pregnant women and not added when requested by PSEP team.
- Funding for home visitation program for substance using women turned away by state for political reasons (Affordable Care Act).

Discoveries

- The Community Systems Map helped identify other organizations to invite to join the PSEP team.
- Existing relationships helped provide a framework for collaboration as the substance abuse problem intensified in our state. The extent of the problem spurred involvement and a commitment to work together.

Impacts of Participation

Members continue to work together to address this issue and share information, resources, training opportunities. The travel team and the extended team generated great synergy in the state and members continue to work on the issue and provide leadership in many venues.

In addition, this collaboration allowed several unanticipated opportunities to be pursued successfully, including

- A grant application was submitted by a PSEP member for funding from the March of Dimes and the Children's Board for a statewide drug summit on December 14, 2012.
- SBIRT was included in a Strong Start grant application and funding was awarded to implement this pilot at five sites in three counties with approximately 1,330 Medicaid clients annually.
- Funding for the home visitation program for substance using women that was turned away by the state for political reasons (Affordable Care Act) in 2012, was awarded in April 2013 to the Florida Association of Healthy Start Coalitions, a non-profit organization. The federal home visiting funding will allow that program and several others to continue for multiple years.

Intended Long Term Impacts

The team will continue to pilot SBIRT with a new Strong Start grant award from the Centers for Medicare and Medicaid Services, and with evidence-based education and support services for pregnant Medicaid beneficiaries in OB offices using a Maternity Medical Home model to improve prenatal services and decrease costs. The Strong Start program will serve as a pilot for redesign of programs for pregnant women and infants under Florida's Medicaid Reform.

Work Ahead

- Integration of SBIRT into Healthy Start redesign.
- Exploration/utilization of environmental strategies on Rx drug misuse.
- Collaborating with local law enforcement to advocate for regulation and appropriate prescribing by providers (statewide drug monitoring system and continued closing of pill mills).
- Coordination between local Substance Exposed Newborn Task Force groups.
- Creation of a *Toolbox for Substance Exposed Pregnancies* that will be disseminated widely to health care professionals, treatment centers and the public.
- Continued education about the effects of prescription drugs during pregnancy.
- Training of professionals, in a session titled *Brief Screening and Intervention for Women at Risk for Substance Abuse*.
- Multiple local, statewide and national presentations by team members, including:
 - *The Impact of Substance Abuse on Children and Families* at the Florida Early Childhood Conference.
 - A session on substance abuse in pregnancy at the Florida Association of Healthy Start Coalition's 2013 conference.
 - A poster presentation of the PSEP project will be done for the Florida Perinatal Quality Collaborative conference.

Baltimore, Maryland

“Baltimore City’s success in reducing and maintaining lower infant mortality over three years can be attributed to: targeting preventable deaths; developing cross-sector task forces that reach women and men of reproductive age citywide; and making infant mortality a Mayoral priority. Through this multi-level conceptual framework, the PSEP Collaborative made many important accomplishments. The PSEP strategy applies a life course model that intervenes at four levels: policy, provider systems, community, and individual. These four levels affect the full public health pyramid, from patient-centered interventions to actions that influence the health of women and children in Baltimore City.”

- Baltimore Collaborative Team Member

Team Leadership – Rebecca Dineen, MS; Christina Trenton, LCSW-C, CAC-AD

Additional Team Membership – Jennifer Han, ScM; Gena O’Keefe, MD; Regina Rutledge, MPH; Jennifer Epstein, MS; Elizabeth Salisbury-Afshar, MD, MPH

Overall Strategies

The Baltimore PSEP Collaborative is co-led by the Baltimore City Health Department (BCHD) and the Baltimore Substance Abuse Systems (bSAS). Through an intensive planning process, the PSEP Collaborative – with representation from a dozen city agencies, treatment programs, medical systems, and academic institutions – has developed the following strategies:

- PSEP will integrate evidence-based SBIRT into WIC clinics, Title X family planning clinics, and Federally Qualified Health Centers (FQHCs) to facilitate the early identification and referral of women (and men) who report risky use of alcohol, tobacco use, and use of illegal substances to prevent substance abuse during preconception and pregnancy.
- PSEP will expand clients’ access to contraceptive services at drug treatment and needle exchange programs, ensuring that clients have the information, counseling, and access needed for informed choice to prevent unplanned and unwanted pregnancy among substance-abusing women.
- PSEP will increase access to evidence-based harm reduction and smoking cessation interventions to clients served by the City’s six home visiting programs, BCHD’s asthma reduction program, WIC clinics, and Health Care Access Maryland to prevent secondhand exposure to tobacco smoke during pregnancy and the first year of an infant’s life.
- PSEP will advocate for policies that address critical gaps in data collection and service delivery related to PSEP activities. PSEP will advocate for universal toxicology screening at all birthing hospitals and the development of standard guidelines for responding to positive cases. PSEP also will advocate for State-level policies that encourage drug treatment programs to provide a basic package of family planning-related services, including screening clients for unmet need at intake.

Local Picture

In Baltimore City:

- Health risk behaviors common among women during pregnancy include: smoking, alcohol and illicit drug use/abuse, and lack of prenatal care.
 - 19% of women reported smoking during the three months pre-pregnancy, and nearly 9% of women of reproductive age reported cigarette use during pregnancy; indicating that among the high proportion of women of reproductive age who are smoking, more than half are continuing to smoke during pregnancy.
 - 14% of women reported binge drinking during the three months pre-pregnancy, and 1.5% of women reported continued alcohol use during pregnancy.
- Nearly 5% of women receive late prenatal care, which is care initiated during the second or third trimester; or no prenatal care.
- 1.4% of women received no prenatal care during their pregnancy, and entered the healthcare system at the time of delivery.
- The infant mortality rate was 13.5% in 2009 - the fourth highest infant mortality rate in the United States. The IMR in 2011 was 10.5, driven largely by a reduction in SIDS. We believe our citywide safe sleep campaign contributed to this reduction.
- Nearly 13% of women delivered low birth weight in 2009.
- 13% of deliveries were preterm births
- Of all live births from 2001-2009, nearly 60% of these pregnancies were unintended.

Baltimore City

Preventing Substance Exposed Pregnancy Collaborative

Collaborative Process

The Collaborative Process is a continuous cycle. It begins with **Partnerships** and **Cross Sector Collaboration**, which lead to **Review**, **Scan**, **Prioritize**, and **Direct**. An arrow points from the end of the cycle back to the beginning, indicating a continuous process.

Life Course Model Program Framework

The Life Course Model Program Framework consists of four concentric circles representing different levels of influence: **individual**, **community**, **provider**, and **policy**. To the left of these circles are silhouettes of a family (a woman, a man, and two children).

Vision: All women in Baltimore City to have healthy substance-free pregnancies and live substance free across their life span.

Increase use of SBIRT	Increase access to family planning	Improve indoor air quality	Improve data collection
Increase access to Screening Brief Intervention Referral to Treatment	Improve access to contraception and counseling at substance treatment facilities	Prevent secondhand exposure to tobacco smoke during pregnancy and the infant's first year of life	Advocate for policies addressing gaps in data collection

Reduction in infant Mortality

Major Accomplishments

Partnerships Developed:

- State institutions
 - Department of Health and Mental Hygiene – Title X
- City institutions
 - Baltimore Substance Abuse Systems (bSAS)
 - Adolescent and Reproductive Health (ARH)
 - State and Local Office of Women, Infants and Children (WIC)
 - Division of Sexually Transmitted Disease
 - Department of Social Services
 - City prenatal and infant home visiting programs
 - School Health
- Academic and Medical Institutions
 - University of Maryland
 - Johns Hopkins University
- Health care organizations
 - Title X clinics and Planned Parenthood
 - Substance abuse treatment organizations
- Consultants
 - Mosaic Consultants
 - Johns Hopkins University Center for Communication Programs

Needs Assessment Completed:

- Literature review showed limited research addressing family planning for drug users or individuals in drug treatment
 - Several studies addressed intendedness of pregnancy among actively using women.
 - Several studies addressed contraceptive use rates among women in drug treatment.
 - One study included focus groups in treatment centers about perceptions of family planning /contraception.
 - One study compared women's choice of contraception during pregnancy and method received postpartum.
- Site mapping shows heavy emphasis on treatment versus prevention
- Data analysis showed that of the 5,209 women enrolled in

treatment in 2011, 71% were between the ages of 11 and 46 years

- The percentage of women in the 15-29 age group has been increasing among Baltimore City female residents of reproductive age admitted to bSAS-funded treatment programs
- Prevention Medicine Resident completed survey of bSAS-funded treatment organizations.

Results included:

- Most treatment centers are not asking about contraception at intake.
- Most treatment centers are not providing any formal family planning education.
- Most treatment centers are not providing contraceptive services onsite (aside from providing free condoms).
- Most treatment centers are interested in utilizing family planning resources.

Recommendations include:

- No one-size fits all method, select sites strategically.
- Treatment centers vary in available staff and volume of clients served (some have MD, NP, PA, RN available and others do not).
- Programming for intensive outpatient programs (9 hours per week) may be different from programming for clients in residential programs.
- Some sites have programs specifically for women with young children, others serve much older populations.
- Minimize paper work.
- Don't forget about incentives.
- Use existing supportive staffing such as the HPAs from bSAS for future work.
- Expansion of SBIRT in Planned Parenthood Maryland (PPM)
 - Consultant completed work flow analysis, integration into the electronic health records and trainings with Baltimore City staff and providers.
 - PPM will use Baltimore City clinic as a pilot site and then plans to integrate SBIRT statewide.
- Universal infant toxicology screens
 - Based on a presentation of substance use data as a part of the Health Department's MCH birth profile, Harbor Hospital has agreed to universal infant toxicology testing. There is now only

one birthing hospital in Baltimore City that does not require universal screens for infants.

Major Challenges

- Limited data on the problem of substance use/abuse in the city.
- Limited literature on effectiveness of including family planning counseling and services in drug treatment centers.
- Major agency changes – integration of Mental Health and Substance treatment services.
- Staff work in silos in and across public agencies.
- Financial issues – e.g., according to School Health, they had to eliminate SBIRT because they did not have the funding to continue with it.

Discoveries

- All partners linked in any way to the work must be invited to the table during all stages of the planning process.
- Creativity with SBIRT implementation is key for sustainable success -- there is no one size fits all approach.
 - Major differences in work flow of PPM, WIC, and FQHCs.
- Ultimately, a collaborative needs funding to maintain interest.
- It is essential to put PSEP and SBIRT into a context of a much bigger picture to make the pitch to state agencies (in Maryland, they have linked it back to the Governor's infant mortality plan).

Impacts of Participation

The formation of the Baltimore City PSEP Collaborative was the catalyst needed to bring together this specific set of partners to work toward the goal of preventing substance exposed pregnancies. Too often agencies work in silos and do not have the opportunity to interface regularly. Over the last year and a half the Collaborative has met monthly, developed a comprehensive multi-year strategic plan, and had two posters accepted at national conferences.

Some specific impacts of this project include:

- Identifying and getting the right people at the table to tell the story.
- Discovering the major gap in and desire for family planning counseling and treatment at drug treatment centers.
- Having major city partners self-identify for training in SBIRT. Mosaic Consulting has begun working with these sites to integrate SBIRT

into services.

- Title X clinics including Planned Parenthood
- WIC
- Exploration of changes at the policy level regarding toxicology screens.
- Drafting of a joint strategic plan that we can now market to funders.

Intended Long Term Impacts

In addition to continued cross-agency collaboration, the objectives of the PSEP collaborative illustrate the intended long term impact of our work:

- Prevent substance abuse during preconception and pregnancy
- Prevent unplanned and unwanted pregnancy among substance-abusing women
- Prevent secondhand exposure to tobacco smoke during pregnancy and the first year of an infant's life
- Advocate for policies that address critical gaps in data collection and service delivery related to PSEP activities

Work Ahead

The team is also moving forward with two objectives from their Strategic Plan:

- **Prevent unplanned and unwanted pregnancy among substance-abusing women**
 - Implementing SBIRT into Planned Parenthood Maryland
 - Providing training to WIC on Substance Abuse and Resources in Baltimore
- **Prevent substance abuse during preconception and pregnancy**
 - Submitting proposal to local foundation to request funds for formative research proposal on the integration of family planning services into Baltimore City treatment centers

Some immediate steps ahead of us include:

- Continuing the Collaborative, with at least one potential funding source identified—OSI
- Conducting qualitative research to identify best methodology and messaging for implementing SBIRT in WIC and FP clinics and for introducing FP in treatment centers
- Exploring best practices in smoking cessation and the possibility

of the use of air cleaners as a more comprehensive strategy to improve indoor air quality

- Continuing the conversation on policy proposals and the potential implications of these policies

REPLICATING THEIR ADVICE TO OTHER COMMUNITIES

Planning

- Customer/partner centric planning – begin where the people are.
- Have a strategic plan – it gives direction, focus, and steps to move the mission forward.
- Take as much time as needed to build relationships before embarking on program planning.
- Allocate enough time to coordinate the effort.

Partners

- Key to this effort is the diversity of partners in your collaborative; representation from the public, private, research and medical communities allows the group to develop a comprehensive multi-level plan.
- Celebrate successes of the individual partners and the team as a whole.
- Define a goal that brings diverse partners together.
- Don't exclude any interested participant.

Politics and "big picture"

- Political will and support is extremely helpful.
- Have a multidisciplinary approach and continuously seek out missing representation.
- Identify the issue with data to gain public awareness and buy-in of partners; recruit motivated individuals; use group processes for developing strategies and ownership of the work involved.

Structure

- Ensure strong organizational support.
- Be willing to let the team determine how the work gets done.
- Adopt a trauma-informed process.
- PSEP follows a program development framework that involves: reviewing the epidemiology and literature; then conducting an environmental scan of existing programs, resources, and policies; next, carrying out a prioritization process to assess the feasibility and potential impact of program interventions/policy directions;

and finally, identifying a monitoring and evaluation framework. Consider using policy level interventions, service delivery interventions, community mobilization actions, and individually-based activities.

Flexibility and Adaptability

- Be flexible when membership changes and make room at the table for other disciplines.
- Take advantage of other opportunities related to the work as they become available or as the stars align.

Consistency

- Internal leader/champion.
- Prioritize the voices of those affected by the issue that the collaborative is trying to address.
- Steady, long term commitment (over years).

Resiliency

- You have to know when to let go of an idea and not get discouraged that the work is impossible – the collaborative has to have many options for achieving objectives.

CONTACT INFORMATION

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APPENDICES

- A. Team Products
- B. CityMat**CH** and NCBDDD Products
- C. Toolkit (Tools 1-6, developed for the collaborative)

Link to the resources below:

<http://www.citymatch.org/prevention-substance-exposed-pregnancies-collaborative-psep/psep-toolkit>

A. Team Products

Sonoma:

Confidential Women's Health Questionnaire:

<http://webmedia.unmc.edu/Community/CityMatch/PSEPFinalReport/LombardiWomensHealthQuestionnaire11.pdf>

(For provider use)

<http://webmedia.unmc.edu/Community/CityMatch/PSEPFinalReport/SBIDRAFIntegratedscreeningtoolVISTA0913.pdf>

Provider Talking Points:

<http://webmedia.unmc.edu/Community/CityMatch/PSEPFinalReport/ProviderBriefTalkingPointsOct2012.pdf>

Women's Health Integrated Screening Tool:

<http://webmedia.unmc.edu/Community/CityMatch/PSEPFinalReport/SBIDRAFTIntegratedscreeningtoolEngandSpanDUPLEX102012.pdf>

Workflow Instructions:

<http://webmedia.unmc.edu/Community/CityMatch/PSEPFinalReport/WorkflowinstructionsSTOCSRCHC.pdf>

Prescription Medication Warning Flyer:

<http://webmedia.unmc.edu/Community/CityMatch/PSEPFinalReport/FinalpreventRXmisuse&diversionEnglish.pdf>

(In Spanish):

http://webmedia.unmc.edu/Community/CityMatch/PSEPFinalReport/FinalpreventRXmisuse&diversion_Spanish.pdf

Reproductive Life Plan For Women:

<http://webmedia.unmc.edu/Community/CityMatch/PSEPFinalReport/MyReproductiveLifePlanversion6.pdf>

Multnomah:

Evaluation Plan:

<http://webmedia.unmc.edu/Community/CityMatch/PSEPFinalReport/EvaluationPlanMultnomah.pdf>

Historical Trauma:

http://webmedia.unmc.edu/Community/CityMatch/PSEPFinalReport/HistoricalTraumaCommunityCollaborative_Heater_Ellis_FGC.pdf

Project Timeline:

http://webmedia.unmc.edu/Community/CityMatch/PSEPFinalReport/multnomahCityMatCHProjectTimeline_V3.pdf

Fact Sheet:

<http://webmedia.unmc.edu/Community/CityMatch/PSEPFinalReport/Multnomahfactsheet.pdf>

Trauma informed Process:

<http://webmedia.unmc.edu/Community/CityMatch/PSEPFinalReport/MultnomahTraumainformedprocess.pdf>

Denver:

Fact Sheet:

<http://webmedia.unmc.edu/Community/CityMatch/PSEPFinalReport/Denverfactsheet.pdf>

Dayton:

FASD Task force Fact Sheet:

<http://webmedia.unmc.edu/Community/CityMatch/PSEPFinalReport/DaytonFASDTaskForce.pdf>

Pinellas:

Strategic Logic Model:

<http://webmedia.unmc.edu/Community/CityMatch/PSEPFinalReport/PinellasStrategicLogicModelforPSEPdraft.pdf>

Systems Map for the Prevention of Risky Behavior:

<http://webmedia.unmc.edu/Community/CityMatch/PSEPFinalReport/pinellasSystemsMap.pdf>

Your Baby and Alcohol Poster:

<http://webmedia.unmc.edu/Community/CityMatch/PSEPFinalReport/Floridaattachment4.jpg>

Your Baby and Marijuana Poster:

<http://webmedia.unmc.edu/Community/CityMatch/PSEPFinalReport/Floridaattachment5.jpg>

Your Baby and Opiates Posters:

<http://webmedia.unmc.edu/Community/CityMatch/PSEPFinalReport/Floridaattachment7.jpg>

<http://webmedia.unmc.edu/Community/CityMatch/PSEPFinalReport/Floridaattachment6.jpg>

Newborns and Rx Drug Abuse Infosheets:

<http://webmedia.unmc.edu/Community/CityMatch/PSEPFinalReport/Floridaattachment2.jpg>

<http://webmedia.unmc.edu/Community/CityMatch/PSEPFinalReport/Floridaattachment3.jpg>

Baltimore:

B'More for Healthy Babies Initiative:

<http://www.healthybabiesbaltimore.com/>

EM Health Risk Questionnaire:

<http://webmedia.unmc.edu/Community/CityMatch/PSEPFinalReport/BaltimoreEMHealthRiskQuestionnaire.pdf>

SBIRT Patient Questionnaire

<http://webmedia.unmc.edu/Community/CityMatch/PSEPFinalReport/BaltimoreSBIRTPatientQuestionnaire.pdf>

B. CityMatCH and NCBDDD Products

PSEP Collaborative Timeline

<http://webmedia.unmc.edu/Community/CityMatch/PSEPFinalReport/CityMatCHTimeline.pdf>

Local Perspectives and Recommendations on Neonatal Abstinence Syndrome:

<http://webmedia.unmc.edu/Community/CityMatch/PSEPFinalReport/NASarticle.pdf>

National Center on Birth Defects and Developmental Disabilities Fact Sheet:

<http://webmedia.unmc.edu/Community/CityMatch/PSEPFinalReport/NCBDDFASDfactsheet.pdf>

PSEP Collaborative Timeline:

<http://webmedia.unmc.edu/Community/CityMatch/PSEPFinalReport/timeline.pdf>

PSEP Logic Model:

<http://webmedia.unmc.edu/Community/CityMatch/PSEPFinalReport/PSEPPCLoicModel.pdf>

Environmental Scan:

<http://webmedia.unmc.edu/Community/CityMatch/PSEPFinalReport/EnvironmentalScan.pdf>

C. Toolkit

Rapid Bulls-Eye Assessment of Work-to-Date:

<http://webmedia.unmc.edu/Community/CityMatch/PSEPFinalReport/BULLS-EYE.pdf>

Rapid Bulls-Eye Assessment of Work-to-Date Tool for Action Planning:

<http://webmedia.unmc.edu/Community/CityMatch/PSEPFinalReport/BULLS-EYEpart%202.pdf>

Tool 1:

<http://webmedia.unmc.edu/Community/CityMatch/PSEPFinalReport/Tools1and3.pdf>

Tool 2:

<http://webmedia.unmc.edu/Community/CityMatch/PSEPFinalReport/Tool2.pdf>

Tool 3:

<http://webmedia.unmc.edu/Community/CityMatch/PSEPFinalReport/Tools1and3.pdf>

Tool 4:

<http://webmedia.unmc.edu/Community/CityMatch/PSEPFinalReport/Tool4.pdf>

Tool 5:

<http://webmedia.unmc.edu/Community/CityMatch/PSEPFinalReport/Tool5.pdf>

Tool 6:

<http://webmedia.unmc.edu/Community/CityMatch/PSEPFinalReport/Tool6.pdf>

