Implementation Site Visit Report

Cohort IV State Grantee: American Samoa

Cohort IV Implementation Site Visit

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for the Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment

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Implementation Site Visit:
American Samoa

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Summary: SBIRT Implementation in American Samoa

American Samoa is one of nine States/Territories to have recently undertaken the implementation of SBIRT in its community. The Department of Human and Social Services (DHSS) was awarded an SBIRT State Demonstration Cooperative Agreement in September 2011.

A site visit was made to American Samoa May 21–25, 2012, to review accomplishments and identify areas where technical assistance may help move the program forward. The site visit process included the following components:

Meeting onsite with the project director, core staff, key partners, project evaluators, data coordinator, and American Samoa State agency senior leadership

- Reviewing the implementation plan and schedule
- Reviewing training materials
- Visiting SBIRT implementation sites
- Meeting and talking with wellness and behavioral health counselors
- Meeting with key implementation partners
- Meeting with the policy steering committee chairperson and other members

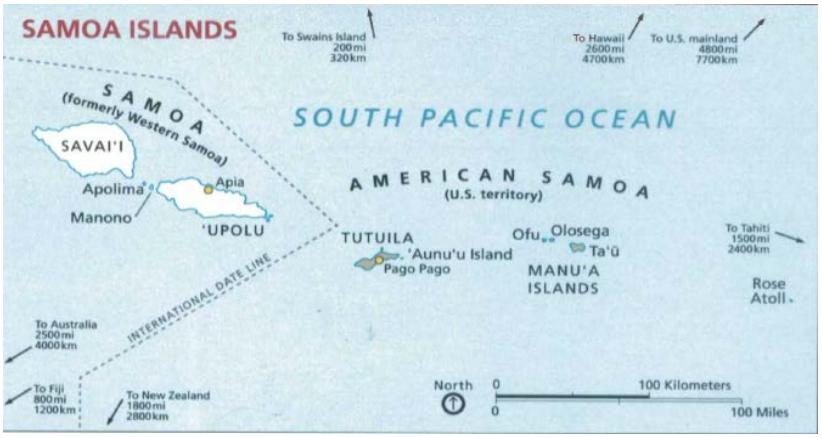
Based on the discussions held during this site visit, several observations were made. First, the American Samoa SBIRT staff is extremely dedicated to improving the lives of persons in their community. This is immediately apparent in the name they chose for their SBIRT program—O le Alofa. Translated to English, the phrase means “the spirit of loving life.”

The O le Alofa SBIRT program has many strengths on which to build during the course of their SBIRT grant. These strengths include the following:

- Flat governmental structure allowing for centralized management of the SBIRT program at the highest level of Samoan government—Allows the program to have more control over project implementation and coordination
- Strong community awareness enhanced through the development and utilization of O le Alofa-branded materials
- High level of buy-in from the partner organizations, specifically the medical community
- Development of screening and brief intervention materials, including the development of the OLA Wellness Questionnaire, which is used as a screening tool and is presented to the patient in both English and Samoan
- A fully staffed leadership team including the project director, clinical director, quality assurance manager, and evaluation team
- Full implementation in three healthcare clinics and the local emergency department within the first 9 months of the grant

While these strengths provide a strong foundation on which the O le Alofa SBIRT program can build, there are also many challenges the team must recognize and address. Implementation sites are online; however, projected targets are not being met and screening results do not match expected levels of need. Both of these issues are impacted by two broad categories: logistical challenges and cultural challenges.

Geographically, American Samoa is located in the South Pacific, 2,600 miles south of Hawaii. The SBIRT staff is challenged with time zone differences and remote access to SBIRT resources developed by other SBIRT grantee programs. Additionally, the primary language spoken by the people they serve is Samoan, not English.



This geographic isolation enhances logistical and cultural challenges that the O le Alofa SBIRT staff needs to address to ensure the success of their SBIRT grant.

Logistically, the O le Alofa SBIRT staff should consider the following recommendations:

- Persons most at risk for unhealthy alcohol use are not presenting at medical centers. To capture persons not seen through the medical centers, community partners need to be fully implemented into the SBIRT program. These partners should include criminal justice, public safety, Employee Assistance Programs (EAPs), and the department of education.
- Because Samoan is the primary language spoken, English-delivered services can be a barrier to building trust and collecting accurate screening information. To build trust and rapport with the persons they are serving, SBIRT staff should be fluent in both English and Samoan. Screening, brief intervention, and brief treatment should be delivered in Samoan when appropriate. Additionally, support materials should be available in both English and Samoan.
- Space is an issue within program sites with concern for patient confidentiality. SBIRT staff should continue to work with program sites to define a space that can be used for brief intervention and brief treatment sessions.
- Self-report screening does not seem to be accurately capturing the level of use by the respondent. The O le Alofa SBIRT program should consider pilot testing a single screener question and then have the wellness counselor complete the OLA Wellness Questionnaire with the respondent in person.
- Currently, the SBIRT program identifies respondents using their medical ID number. This number will not translate into settings outside the medical community. The participant coding system should be reviewed and reevaluated in preparation for SBIRT implementation with community partners.

The Samoan culture also provides specific challenges that will need to be addressed if the SBIRT program is to be successful. The O le Alofa SBIRT staff should consider the following:

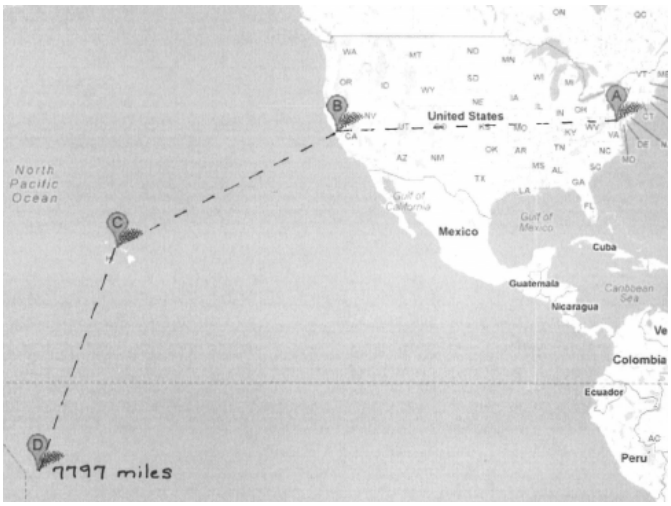
- The chosen screening instrument, the AUDIT, does not appear to be capturing level of need within the Samoan population at the standardized thresholds. O le Alofa SBIRT staff should consider lowering the clinical threshold levels to better capture persons in need of brief intervention and brief treatment.
- The Samoan culture is very private and does not encourage sharing personal business with others. This leads to underreporting of both health and behavioral health problems. Because of this approach to sharing information, a screening instrument alone may not capture an accurate level of use. O le Alofa SBIRT staff should consider a combined screening/brief intervention approach that would provide a more detailed assessment of respondent use and unhealthy behavior.
- Heavy alcohol use is seen as a cultural norm. Alcohol is used in celebration with family and friends. Respondents may not consider their use to be any different or more harmful than that of the elders in their villages. Additionally, the beer of choice in American Samoa is Vailima. Vailima is typically sold in 750 ml (approximately 25 oz.) bottles. Educational materials should be developed in Samoan to address the cultural norm of drinking and to highlight the harmful consequences of risky use, including defining standard drink size.

- Behavioral health is not easily discussed and is often stigmatized. An overall wellness approach linking medical and behavioral health should be implemented. This includes screening for nutrition, tobacco use, and depression within the SBIRT program.

The O le Alofa SBIRT program has done an excellent job of engaging its community and working to create partnerships for implementation. The greatest challenge, however, will be to meet the target numbers for screening, brief intervention, and referral to treatment. The current implementation approach and process is experiencing both logistical and cultural barriers that are impeding the program's ability to reach persons in need, as well as placing the program at risk for losing Federal funding. The considerations detailed in this report should be reviewed and implemented, as appropriate, to address identified barriers and move the program forward.

Introduction

The journey to implementing a successful screening, brief intervention, and referral to treatment (SBIRT) program—much like the journey to American Samoa—can be long and often challenging. It is important to understand the American Samoa environment and culture to better understand the systems in which SBIRT is being designed, implemented, and sustained.



American Samoa History

American Samoa was awarded an SBIRT grant in September 2011 as part of the Substance Abuse and Mental Health Services Administration (SAMHSA) fourth cohort of SBIRT State Demonstration Cooperative Agreements.

American Samoa is an unincorporated territory of the United States located 7,797 air miles from Washington, DC. The route to get there took the site visit team from Washington, DC, to San Francisco, California. From San Francisco the team travelled to Honolulu, Hawaii, where travelers must wait until either Sunday or Thursday to fly into American Samoa. Flights from the United States only go into and out of American Samoa 2 days a week—Sunday and Thursday.

America Samoa Environment

The area of American Samoa is approximately 76 square miles, housing just over 55,000 people on record, although the local government believes the actual number of people (including the resident alien population) is closer to 75,000, with 80 percent of the alien population comprised of people from Western Samoa, other Pacific Islanders, and Asians.

Coming from Honolulu, flights arrive on the island around 11:00 p.m. Even at this late hour, the airport bustles with family and friends waiting to greet people with flower or candy leis.

American Samoa has a tropical rainforest climate with no real dry season. Over the course of a year the temperatures typically range from 77 to 88 degrees Fahrenheit. Unlike the United States, summer does not mean extended daylight time. Daylight only varies from just over 11 hours of daylight in June to 13 hours of daylight in December, with the latest sunset taking place at 6:59 p.m. in January. For most, the work day ends in time to be home with family for dinner around 5:00 p.m.

American Samoa Population

Overall, the American Samoa population is very young, with almost half younger than 20 years of age. Males typically slightly outnumber females. Samoan is spoken by over 90 percent of the population, while nearly 3 percent speak English. This makes it critical for the SBIRT Team to ensure that screening, brief intervention, and treatment are offered in both Samoan and English. Education is delivered through 23 primary schools and 6 secondary schools, all operated by the American Samoa Department of Education. There is no 4-year college located on the island. The American Samoa Community College provides the only postsecondary education. Overall, there is a 98 percent literacy rate among the American Samoan people.

Employment on the island falls into three relatively equal-sized categories: the public sector, the single remaining tuna cannery, and the rest of the private sector. The overwhelming majority of public sector employees work for the American Samoa territorial government. The one tuna cannery, StarKist, exports several hundred million dollars' worth of canned tuna to the United States each year. The other tuna cannery, Samoa Packing, a Chicken of the Sea subsidiary, closed in 2009 (laying off 2,041 employees) due to American Samoans being granted minimum wage in 2007. Prior to that time American Samoa was not mentioned in the minimum wage bill and did not have to meet minimum wage requirements. American Samoa's unemployment rate is 23.8 percent, with 88 percent of the population eligible for Medicaid benefits.

American Samoa Health and Health Care

Health continues to be a concern in American Samoa. In 2007, the World Health Organization (WHO) published a report examining noncommunicable disease (NCD) risk factors among the American Samoa population. Findings from this WHO survey highlight the health concerns in American Samoa, including the following:

- 47.3 percent of the population is diabetic.
- 29.9 percent of the population is a regular smoker.
- 93.5 percent of the population is overweight or obese.
- 86.7 percent of the population has poor nutrition habits.
- 99.6 percent of the population was found to have one or more of the major risk factors for NCDs.

Heart disease remains the leading cause of death among the American Samoa population, followed by malignant neoplasm. The increase in chronic diseases in American Samoa is associated with the percentages listed above, including improper nutrition and physical inactivity. Diabetes continues to be a primary concern, with the mean number of deaths due to diabetes increasing significantly each year. Regular heavy use of alcohol and tobacco often exacerbate these health conditions.

There is no fee for service charge for outpatient or community health care in American Samoa. Instead, each American Samoa national is charged a facility fee of $10 per facility visit. Nonresident aliens are charged a $20 facility fee. At the time of the site visit, these amounts were scheduled to increase to $20 for nationals and $85 for nonresident aliens in June 2012. Inpatient services fees are determined on a sliding scale based on a person or family's income and ability to pay. Behavioral health services were just recently added to the American Samoa State Plan as eligible services for delivery and coverage.

While the majority of the population is eligible to receive Medicaid, community health centers and other medical facilities do not bill Medicaid by individual services. DHSS is currently working to develop a methodology for Medicaid billing; however, they first need to determine how to address the 45/55 State match.

American Samoa Culture and Political Structure

American Samoa is a single layer government system, meaning there is no division between State and county/village. Administratively, American Samoa is divided into three districts—Eastern District, Western District, and Manu'a District—and two "unorganized" atolls, Swains Island and the uninhabited Rose Atoll. The districts and unorganized atolls are subdivided into 74 villages. Pago Pago, the capital of American Samoa, is one of the largest villages and is located on the eastern side of Tutuila Island.

American Samoa is led by the Governor and Lieutenant Governor, who are both elected on the same ticket by popular vote for 4-year terms. There are also village fonos (councils) and matais (chiefs) that ensure that local Fa'asamoa (language and customs) and Fa'ametai (protocols) are followed. Chiefs are elected by consensus within the council. Local customs and protocols are still very important to the culture and chiefs are revered as high authority within each village.

American Samoa is a traditionally Polynesian culture in which more than 90 percent of the land is communally owned. Family is very important and villages retain strong cultural beliefs and practices. Fales are found across the island. A fale is a community meeting space that is most often situated by the beach and linked to a specific village or family. These buildings are closely linked to the Samoan system of social organization and chief systems. Culture is also displayed through traditional dress, including the traditional ladies garment, a puletasi, which is a matching skirt and tunic with Samoan designs.

Recent Natural Disaster

The American Samoan population is still recovering from the tsunami that devastated their island on September 29, 2009, when an 8.1 magnitude earthquake struck 120 miles off the coast of American Samoa. The earthquake struck 11.2 miles below the ocean floor and generated an onsetting tsunami that killed more than 170 people in the Samoa Islands. Four waves with heights from 15 to 20 feet high were reported to have reached up to 1 mile inland on the island of Tutuila. Local villages and families were devastated by this traumatic event.

A memorial was resurrected in February 2012, in memory of those who lost their lives. The memorial stands at the location of the island where the tsunami came on land. Much of the surrounding area is still in disrepair from the damage the tsunami created to local homes, businesses, and community buildings. Counseling is still available to those families impacted by the disaster. Many SBIRT wellness counselors were trained to deliver behavioral health services to persons impacted by the tsunami; however, SBIRT is the first exposure wellness counselors have had to motivational interviewing (MI) and cognitive behavioral therapy (CBT) training.

American Samoa Behavioral Health Services

DHSS is responsible for delivering behavioral health services, and was recently established by law in 1997. Before this, behavioral health services were located within multiple government entities. Leilua Stevenson is the current DHSS Director and John Suisala is the DHSS Deputy Director.

The Division of Social Services (DSS) within DHSS is responsible for the oversight and delivery of SBIRT through its Department of Behavioral Health (BHS). BHS oversees delivery of mental health services, substance abuse prevention and treatment services, and SBIRT. BHS also works closely with the American Samoa judicial system and the Office of Highway Safety, as alcohol impaired driving continues to be a significant problem on the island. There were 184 DUI citations issued in FY 2010 and this number continues to increase. There is currently a plan to build a behavioral health center, providing designated space for persons screened and in need of referral to treatment.

Overview

The support and embrace of the Samoan community is felt upon landing on the island of American Samoa. This nurturing is the basis for the O le Alofa SBIRT program. O le Alofa translated to English means "the spirit of loving life." The American Samoan population lives to celebrate and love life. Unfortunately, this celebration often involves unhealthy drinking and eating. The O le Alofa SBIRT program is working to address these risky behaviors through the implementation of substance use screening, brief intervention, and referral to treatment in community-based health centers and the only hospital on the island. The SBIRT program builds on existing prevention work that has been developed and implemented through a Strategic Prevention Framework–State Incentive Grant (SPF–SIG). Through the SPF–SIG, a total of 16 DHSS prevention and treatment staff work within the communities to conduct outreach and psychoeducation services that encourage American Samoans to avoid harmful activities and engage in more positive behaviors designed to enhance their wellness. Even with this intervention, however, alcohol use and unhealthy eating remains prominent in American Samoa. Much of this is driven by the role alcohol and eating play in Samoan culture. Both play a role in celebration and stature. Samoan people are also very private, almost to the point of being secretive. These cultural characteristics come into play as DHSS moves forward with implementing the O le Alofa SBIRT program.

Key Partners

Medical Partners

DHSS is working closely with many medical partners including the department of health, which oversees the community health centers. At the time of the site visit, the O le Alofa SBIRT program was implemented in two community health clinics (Tafuna Family Health Center and Leone Family Health Center) and one public health clinic (Fagaalu Public Health Clinic). An office had been designated in the LBJ Emergency Department with anticipation of beginning delivery of SBIRT services in June 2012.

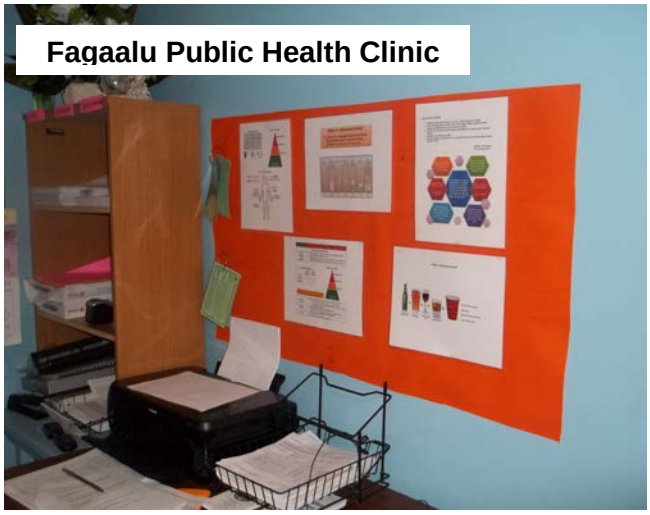
The Tafuna Family Health Center and the Leone Family Health Center are community health centers that see patients with minor health concerns. Each of these centers has a designated space for SBIRT and the support of the primary physician on staff. At the Leone Family Health Center, SBIRT is also being implemented in the dental clinic, through the women and children office, and through the Women, Infant, and Children (WIC) program.

Fagaalu Public Health Clinic is a department of health physical examination office that performs physicals required to receive a work card. Patients who come to this office are not ill, but rather are looking to be medically cleared as healthy to work.

Tafuna Family Health Center

Leone Family Health Center

Fagaalu Public Health Clinic



LBJ Emergency Department

The LBJ Hospital is located across the street from the Fagaalu Public Health Clinic and is the only hospital on the island. In addition to inpatient care, the hospital has an onsite emergency department, six outpatient clinics, and a pharmacy. At the time of the site visit, BHS was planning to implement SBIRT services in the emergency department in June 2012. In preparation for SBIRT, a single room has been designated to provide privacy for the SBIRT wellness counselor to speak with the patient. This room is just off to the left of the new emergency department entrance at the end of a hallway so that it sits separate from the emergency department waiting area.

Community Partners

DHSS has also identified several community partners including the department of education, the Coast Guard, public safety and law enforcement, criminal justice, and local business employee assistance programs (EAPs). Representatives from all these entities attended the SBIRT community training. BHS plans to implement SBIRT in the American Samoa Community College and through the StarKist EAP in Years 2 and 3 of the SBIRT grant. They are also in discussions with public safety and criminal justice to investigate how SBIRT could be implemented in these settings. Prior to the SBIRT community training, there was little understanding of how the evidence base for SBIRT or how the model may be implemented. The training provided a great foundation for community partners and elicited enthusiasm for further discussions with BHS on how to implement SBIRT in a variety of settings.

Grantee Goals and Objectives

The first goal of the O le Alofa SBIRT program is to establish an early detection and intervention system in generalist and specialist primary care and community-based settings that prevents or reduces behavioral health disorders among adults in American Samoa. The second goal is to increase sobriety and self-sufficiency among adults diagnosed with behavioral health disorders through an SBIRT program referral structure that leads clients to clinically appropriate, evidence-based treatment and recovery support services.

Population(s) Served

O le Alofa SBIRT is providing services to persons 18 years of age and older. The project originally targeted screening 10,200 adults annually. Conducting 10,200 screens each year would involve reaching one-third of the adult population, which DHSS has now deemed as not realistic. DHHS submitted a formal request to SAMHSA on May 15, 2012, to reduce these targets. The justification for this request was based on the fact that the original targets overestimated the number of American Samoan adults who utilize the universal screening sites (primary health care centers and the hospital). DHSS is requesting an adjustment to reduce the number of screenings from 10,200 per year to 3,000 per year.

Project Management and Staffing

O le Alofa SBIRT staff include:

- A project director
- An administrative assistant
- A quality assurance manager
- One clinical supervisor
- Eight wellness counselors
- Two behavioral health counselors

The O le Alofa SBIRT program is still looking for additional staff; however, finding persons with the needed education and experience is challenging. Currently, the program uses staff with an associate's degree if they have at least 4 years of experience or a bachelor's degree with 2 years of experience. Persons with a master's degree are very difficult to find.

The program would like to investigate a certification for MI or CBT that could be used to help prepare staff for working on the SBIRT grant.

Implementation Approach

At the time of the site visit, American Samoa was in month 8 of their first grant year. As such, much of the staff time and energy had been expended on planning for SBIRT implementation.

Use of Previous/Current SBIRT Grantee Lessons Learned and Resource

Originally, both medical and community partners were hesitant to implement SBIRT due to concerns with patient privacy, office disruption, and increased work requirements for staff. Using information developed through the Oregon SBIRT Medical Residency grant, O le Alofa SBIRT staff conducted initial presentations with providers and community partners. These trainings helped introduce providers to the SBIRT model and the process for implementation. The trainings also focused on helping medical providers tie SBIRT to overall healthcare cost reduction. The American Samoan SBIRT leadership purposefully invested time upfront to increase acceptance of the SBIRT model through provider training and exposure to resource materials.

Julia Foifua, the clinical supervisor, also gathered lessons learned information from New Mexico, a State SBIRT Cohort I grantee. One of the lessons shared was the importance of involving partners in the planning and implementation stages of development. This included recommending the following steps:

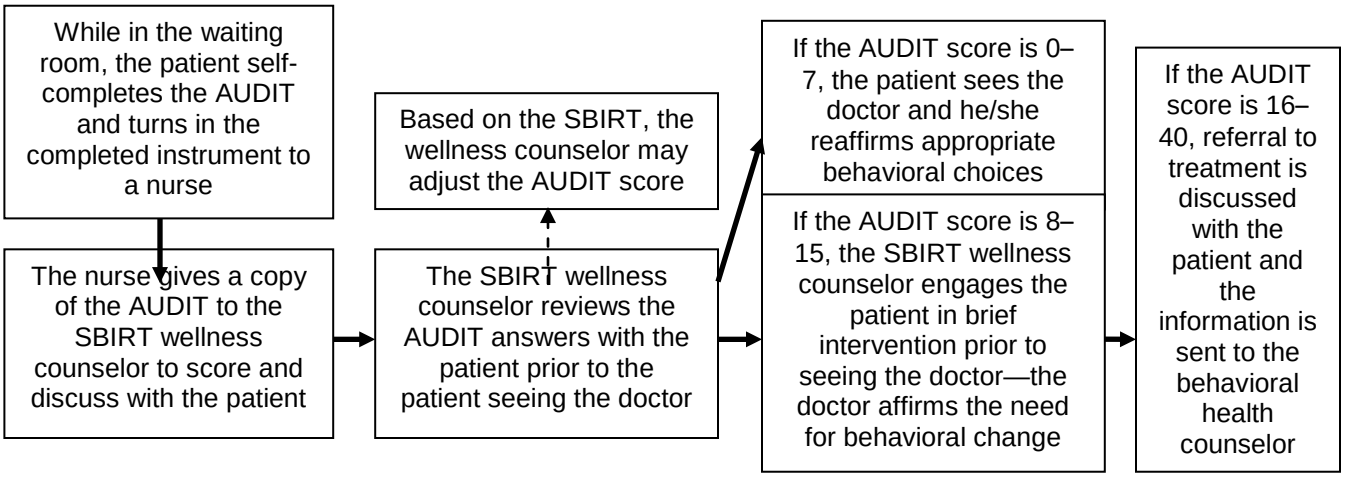
(1) Meet with CEOs/medical directors (MDs) to share concept and seek input
(2) Get memorandums of agreement negotiated and in place
(3) With permission from the CEO/MD, seek input from frontline staff
(4) With input from staff, develop workflows for each site
(5) Pilot test workflows and allow for adjustments and revisions

Integrated Collaboration to Develop Workflow

O le Alofa SBIRT staff invested a significant amount of time individually meeting with staff at each implementation site to seek input on how best to integrate screening and brief intervention into the existing workflow and to address concerns or barriers.

Initial concerns expressed by the medical partners focused on space and confidentiality. Medical staff believed that screening and brief intervention would take too much time and depend on staff resources they did not have. They were also concerned about giving up space to a designated SBIRT office. Finally, there were concerns regarding patient privacy and providing SBIRT wellness counselors with access to patient medical records. During these discussions, the O le Alofa SBIRT staff approached them in terms of developing a partnership rather than as a sales pitch.

For all sites, the following flowchart was developed and is currently being implemented:



Under this model, patients self-report alcohol and drug use via the OLA Wellness Questionnaire that is based on the AUDIT. There is no use of a prescreen in American Samoa. The OL A

Wellness Questionnaire is presented to the patient in both Samoan and English. All SBIRT wellness coordinators are fluent in both Samoan and English. The OLA Wellness Questionnaire was tested and found to be valid and culturally appropriate.

Following this flow, the SBIRT wellness counselor meets with every patient prior to the patient seeing the medical doctor or nurse. The wellness coordinator provides the medical staff with the AUDIT score and a summary of the discussion with the patient so that the medical staff can affirm the positive behavioral choices or the need for behavioral change.

> ***A wellness counselor told our team, "SBIRT works because we are not here to judge you or to determine if you are an alcoholic—we are just here to determine what role alcohol has in your life. This approach must be done in Samoan to engage the patient through both language and an empathetic nature."***

If referral to treatment is indicated based on the AUDIT score, the wellness counselor refers that patient to a behavioral health counselor. The behavioral health counselor completes a more indepth assessment using a combination of the Michigan Alcohol Screening Test (MAST) and Global Appraisal of Individual Needs (GAIN) to assess need for treatment. The clinical supervisor makes all diagnoses of abuse or dependence, working closely with the behavioral health counselors.

Initially, the SBIRT program met with some resistance from implementation site partners regarding the limited availability of space and supplies. Part of the partnership conversations and agreements included a discussion of payment. It was determined through memorandums of

agreement that provider sites would receive one dollar for each completed screening. The providers also receive compensation for the space they provide and assistance with supplies. Initial findings indicate, however, that this approach is not identifying the expected numbers of persons using alcohol at a risky level. Alcohol is a known issue on the island—the SBIRT screening results are just not capturing this need.

Implementation Strategies Moving Forward

The O le Alofa SBIRT team has worked hard to implement SBIRT in three sites by January 2012 and at the time of the site visit was planning to add a fourth site in June 2012. SBIRT has been well received as an intervention model by providers. After only the fifth month of implementation, medical partners are reporting seeing a positive effect from SBIRT. Medical directors speak highly of the ability to make a transformation in a person's health care. Previously, providers were only able to get patients to discuss "occasional" or "social" uses of alcohol. They did not have a tool to help quantify the amount of alcohol use in a person's life and to link this use to health concerns such as diabetes. SBIRT provides an opportunity for health professionals to discuss and affirm either healthy or risky behavior choices and to make recommendations for improving overall wellness. Both behavioral and medical staff agree that the focus of SBIRT needs to be on wellness—this is key to the paradigm shift taking place in American Samoa and in framing the SBIRT program so that it can be sustained beyond the 5-year grant.

As implementation moves forward, the O le Alofa SBIRT staff should also assess the patient flow and volume per site. This information will better inform staffing needs as additional sites are implemented and begin delivering services.

Curriculum Development and Staff Training

Screening and brief interventions are completed by eight wellness counselors, all of whom are employed through DHHS, BHS. When a referral to treatment is needed, the wellness coordinator refers the patient to a behavioral health counselor who is also employed by DHHS, BHS.

While many of the behavioral health staff had received training for crisis intervention after the tsunami, SBIRT was unknown to the staff and required new training. PIMA, the SBIRT evaluator, is leading development and implementation of all curriculum and staff training. Training materials relied heavily on the previous work by New Mexico and Oregon. Julie Foifua , the clinical supervisor, visited the New Mexico SBIRT staff and gathered resources used by their grant in Cohort I. New Mexico seemed like a good fit, as the Native American culture has similarities to the Samoan culture.

PIMA conducted a 2-week training course, with the primary focus on MI. The training course was conducted January 9–20, 2012, and covered MI, motivational enhancement therapy (MET)/CBT sessions, and Government Performance and Results Act (GPRA) data collection. Over 30 physicians and nurses attended a 1/2-day training consisting of a 3–4 hour overview of SBIRT and MI.

After initial trainings were complete, Julia and the PIMA staff conducted numerous roll-plays to build comfort with the SBIRT model. This allowed for plenty of practice time for staff to play both the role of the counselor as well as the nurse or doctor. PIMA staff was also onsite to observe the rollout of SBIRT services in the individual settings.

Ongoing training occurs through onsite and telephonic coaching. Julie, the clinical director, meets weekly with the wellness counselors to review cases and address any concerns. Julia also does onsite coaching at each active SBIRT implementation site. PIMA is available for telephonic coaching calls and to provide ongoing training assistance.

Some initial challenges the team faced included the following:

- Staff needed further training on how to convert larger-size alcoholic beverages into an AUDIT screening assessment. The alcohol of choice in American Samoa is Vailima. Vailima is usually served in a 24 ounce or larger bottle and has 6.7 percent alcohol.
- Staff were uncertain how data that was collected would be entered into a database for the evaluation.
- Staff struggled with collecting GPRA data from patients as they discussed their screening assessment.

These early challenges have been addressed and staff received additional training on data entry and GPRA data collection. Several challenges still remain, however. Primarily these challenges are logistical and cultural. Logistically, the community health centers and hospital do not see as many persons as the SBIRT program originally anticipated. Additionally, persons in need of brief intervention and/or treatment are not those presenting to health facilities.

Staff also struggle with cultural issues. The staff are still seeing numerous zero AUDIT scores. These scores, through further discussion with the patients, are actually higher than the originally reported zero. Additionally, wellness counselors often encounter patients who would rather talk about their family members' alcohol use than their own. For those persons needing brief intervention, there are cultural differences that impact how MI is completed, including differences in how stages of change are interpreted. Finally, substance abuse treatment is not readily accepted by the American Samoan people. Even presented with an AUDIT score indicating the need for treatment, patients are refusing to speak with a behavioral health counselor.

These logistical and cultural challenges will need to be addressed to ensure that O le Alofa SBIRT can deliver services to the number of individuals they targeted in their grant.

Use of Electronic Medical Records (EMR)/IT

LBJ Hospital utilizes electronic health records. The community health centers and the hospital also maintain a patient database to allow for unified record documentation. Patient records are coded with a unique patient identifier. This patient identifier serves as the SBIRT participant identification number.

Providers were initially concerned with patient confidentiality and access of medical records by wellness counselors. To address this concern, wellness counselors scan the SBIRT screening and brief intervention material so that it can be entered into the medical record by the medical staff.

Data Collection

PIMA Prevention is partnering with DHSS to lead the SBIRT staff training and oversee data collection and evaluation. PIMA is located in Phoenix, Arizona, and makes four to six onsite visits to American Samoa annually.

Patients do not typically have one primary care doctor, but rather utilize the community health clinics to receive primary care. A unique patient ID number is used to track patient care through both the department of health (community health clinics) and the hospital. This number was chosen as the SBIRT participant identification code. The patient ID number does not, however, track service provided by setting. While this patient ID number is unique to the individual and duplication of screening does not seem to be an issue, this current system does not allow for tracking of service delivery by site. The patient ID number is not unique to a medical setting; therefore, it is not currently possible to track where an individual screening or brief intervention encounter occurred.

DHSS hired a local data coordinator who works closely with PIMA staff to enter and transmit the data. The data coordinator picks up data from the wellness and behavioral health counselors twice weekly—on Tuesdays and Fridays. The data coordinator then enters all the information into a database that is electronically downloaded every 2 weeks by PIMA staff in Phoenix, Arizona. PIMA staff has weekly calls with the data coordinator each Wednesday to review any questions or concerns.

All data is currently being entered directly into the Services Accountability Improvement System (SAIS). DHSS inquired about developing a local database that would allow for additional data analysis. PIMA considers this a duplication of effort, so a local system has not been developed. A quality assurance manager has been added to the local SBIRT team, however, and she is tasked with analyzing processes, protocols, and project needs. She may determine that a local system is needed to best meet the quality management needs of the project.

There were some initial concerns about coding for those patients who originally scored a zero on the AUDIT, but upon further discussion with the wellness counselor it was determined that those patients received a brief intervention. PIMA worked with clinical staff and the data

coordinator to ensure that in this circumstance the AUDIT score is changed in the data reporting system.

PIMA has limited experience with SBIRT data collection and GPRA. Additional GPRA training for the evaluation staff would be beneficial. Additionally, there is currently no evaluation plan that outlines the data collection and analysis plan. A detailed evaluation plan should be completed.

Grantee Evaluation Findings

From the startup of data collection in January 2012 through May 2012, 1,446 screenings had been completed and only 26 were coded as duplications. The total number of unique screenings completed as of May 2012 was 1,420.

Among the 1,420 persons screened, 59.7 percent were female, 39.9 percent were male, and 6 people were identified as transgender. The average age of persons screened was 37 years, with ages ranging from 12 to 88 years of age. The vast majority (97.7 percent) of participants identified their ethnicity as Pacific Islanders. There have been minimal cases in which illicit drug use was reported. Alcohol is the primary substance discussed.

The screening questionnaire does not seem to be picking up all risky alcohol and drug use. While other studies have reported risky alcohol use at rates of 30 percent of the population or higher, 80.2 percent of persons screened through O le Alofa SBIRT reported no alcohol use at all and only 6.6 percent reported moderate or high-risk drinking behavior in the past year. Of the 1,446 persons screened:

- 1,317 (91 percent) received a screening only
- 119 (8 percent) received a brief intervention
- 5 (.5 percent) received brief treatment
- 5 (.5 percent) received a referral to treatment

These findings do not match other reports of alcohol use and treatment need collected through national surveys.

SBIRT outcomes targets are for adults receiving brief intervention. The measurable objective will be a 50 percent reduction in past month substance use. For adults completing brief and/or specialty treatment, measurable objectives will include: (1) an 80 percent reduction in past 30-day alcohol use, (2) a 90 percent reduction in alcohol/drug-related legal consequences, and (3) an 80 percent rate of demonstrated improved health and/or mental health status.

Little information is available, however, on patient outcomes. Currently, only one person has been identified as eligible for followup. With the limited data available on patient impact, the

DHSS Director is concerned that the SBIRT program will not receive the support necessary for sustainability.

Policy Steering Committee

At the time of the site visit, the policy steering committee was still in formation. Identified members of the committee include the following:

- Dr. John Tuitele, Chief Physician, Tufuna Community Health Center
- Dr. Aloiamoa Anesi, Chief Medical Officer, American Samoa Medical Center Authority
- Dr. Emelia Le'I, Dean of Student Services, American Samoa Community College
- Terrie Bullinger, Assistant Attorney General, Office of Legal Affairs
- Danny Pa'u, Personnel Manager, Starkist Samoa
- John Suisala, Deputy Director, Department of Human and Social Services

The policy steering committee is an impressive group of qualified and well-connected professionals. This group just started to discuss priorities for their team, including examining Medicaid reimbursement and looking at a certification program for screening and brief intervention. They are also prioritizing program areas in which to implement SBIRT, including the criminal justice system and the Starkist EAP.

The need for documentation to help clarify committee member roles and responsibilities was identified. Additionally, the team would like to develop a strategic planning document that helps guide the work of the team members as the grant continues.

Summary of Grantee Performance

O le Alofa SBIRT has done a great job of enhancing interest in SBIRT among medical providers and public health agencies. There has been tremendous effort invested in getting medical community buy-in and in establishing a partnership between medical and behavioral health. These efforts provide a solid foundation for building and sustaining SBIRT. The challenge faced by the program is in reaching their target numbers for screening and brief intervention. To meet this challenge, the team will need to reassess logistical processes and cultural barriers. They will also need to invest in adapting existing materials to the Samaon language, as well as to the Samoan cultural norms.

APPENDIX A – Analysis of Grantee Performance (to date)

Grantee Organization and Leadership

STRENGTHS

- American Samoa has a flat government structure, centralizing management of SBIRT.
- Senior leadership in American Samoa is highly committed to the successful implementation and sustainability of the program.
- O le Alofa SBIRT staff members are very dedicated to improving the lives of persons in their community. The project director and clinical director are both highly experienced grant administrators and clinicians.
- Strong collaborative relationships have been established within the medical community.
- High level of buy-in has been achieved from partner organizations, especially medical partners.
- There is a low-cost health care system based on facility fees rather than fee for service.

CHALLENGES

- The program has only one clinical director who is responsible for managing all clinical staff.
- SBIRT implementation in medical care settings is not reaching all persons in need.
- Health care is primarily funded through Federal dollars that vary in support annually.

Potential Enhancements		Grantee Resources To Be Used	Will Request TA From CSAT	Information Requested
1	Consider the addition of a second clinical director	X		
2	Expand SBIRT services into criminal justice, public safety, EAP programs, and department of education	X	X	
3	Use policy steering committee members to review current reimbursement structure and to determine how Medicaid reimbursement for SBIRT should be managed	X		X

Program Implementation

STRENGTHS

- Community health medical directors are strong advocates of the SBIRT program.
- The SBIRT program has developed a partnership with the only hospital on the island.
- The SBIRT staff practiced a very collaborative approach to engaging medical partners, ensuring minimal issues with workflow and implementation.

CHALLENGES

- The unique participant ID is linked to the healthcare system.
- The screening tool is not capturing the expected number of persons in need of brief intervention, brief treatment, and referral to treatment.
- The screening tool does not include questions targeting nutrition, tobacco use, or mental health.
- Only the Wellness Questionnaire is translated to Samoan.
- The current data has very low rates of brief treatment and referral to treatment.

Potential Enhancements		Grantee Resources To Be Used	Will Request TA From CSAT	Information Requested
1	The SBIRT program should consider using a unique participant ID that is not linked to the healthcare system	X		
2	The SBIRT program should consider using a single question prescreener	X		
3	The addition of wellness questions addressing nutrition, tobacco use, and mental health should be considered for screening	X		
4	The wellness counselor may want to complete the Wellness Questionnaire in person with the participant and eliminate self-report	X		
5	Request TA to translate additional SBIRT materials to Samoan		X	
6	The SBIRT program should investigate lowering the current AUDIT thresholds for brief intervention and brief treatment	X		
7	Brief treatment delivered at the program site immediately following brief intervention may improve target number completion	X		
8	A process assessment should be completed to analyze patient volume and program site space	X		

Training and Workforce Development

STRENGTHS

- The SBIRT program has a fully staffed senior management team.
- All SBIRT staff received a comprehensive 2-week training that included MI and cognitive behavioral health training.
- Extensive training materials were developed by PIMA in preparation for staff training and workforce development.

CHALLENGES

- There are limited persons with advanced postsecondary education to provide SBIRT services.
- The remote location of American Samoa makes it difficult to bring in external experts to train staff.
- There is only one clinical director who currently serves as the clinical supervisor for all SBIRT staff.
- The SBIRT clinical director is the only person currently diagnosing alcohol abuse or dependence.

	Potential Enhancements	Grantee Resources To Be Used	Will Request TA From CSAT	Information Requested
1	Request TA to have the Samoan medical doctor who has worked with Catholic Social Services conduct enhance MI training.		X	
2	Request TA to develop an e-learning tool for SBIRT Certification.		X	
3	Establish a system to tape brief intervention sessions and send the recording to Motivational Interviewing Trainer (MIT)-certified reviewer for ongoing staff training and development.	X		
4	Consider the timeline and delivery of enhanced brief treatment training.	X		
5	Send Georgia and Massachusetts' brief treatment curriculum materials for reference.			X

Evaluation

STRENGTHS

- The PIMA evaluation team has been comprehensively engaged in all planning and implementation.
- The evaluation team is making regular onsite visits to meet face to face with the SBIRT staff.

CHALLENGES

- The program has a very low rate of persons eligible for followup (only one person identified at the time of the site visit).
- The evaluation staff demonstrated confusion regarding GPRA coding for brief intervention, brief treatment, and referral to treatment.
- There is no evaluation plan.
- All data is being managed through the SAIS system only.

Potential Enhancements		Grantee Resources To Be Used	Will Request TA From CSAT	Information Requested
1	Establish clarification for GPRA coding			X
2	Develop a detailed evaluation plan	X		
3	Send examples of other grantee evaluation designs/plans			X
4	The program would benefit from a detailed protocol for implementing followup with participants	X		
5	A locally maintained database may support further analysis and evaluation of data	X		

Policy Steering Committee

STRENGTHS

- The policy steering committee includes influential community partners.

CHALLENGES

- The policy steering committee is still under development and in need of resources to guide priorities and responsibilities.

	Potential Enhancements	Grantee Resources To Be Used	Will Request TA From CSAT	Information Requested
1	Develop a policy steering plan that includes: (1) priorities, (2) timelines and milestone, and (3) member roles and responsibilities	X		
2	Consider contacting representation from the Coast Guard and/or Port Authority for participation on the policy steering committee	X		
3	Send an example of a policy steering committee plan			X

Sustainability

STRENGTHS

- There is tremendous community awareness and support for the SBIRT program.
- DHSS has already begun discussions on including funding for SBIRT in the Block Grant.

CHALLENGES

- There is limited outcome data available to support the ongoing need for SBIRT.
- Staff resources are limited.
- Cultural norms toward high-risk alcohol use are very strong.

Potential Enhancements		Grantee Resources To Be Used	Will Request TA From CSAT	Information Requested
1	Begin to develop a program sustainability plan	X		
2	Send an example of a sustainability plan developed by another grantee			X
3	Develop a plan for training future staff in preparation for staff turnover	X		