

**HRSA SPNS American Indian/Alaska Native Grantees Meeting  
Parklawn Building - Conference Room G  
March 20-21, 2003**

**I. Greetings and Introduction - (Betty Duran)**

**Welcome by Dr. Lois Eldred, Director of SPNS. She introduced Dr. Deborah Parham, Director of the HRSA HIV/AIDS Bureau. She advised**

- 1 Just passed 2003 Budget and is getting ready for 2004 Budget
- 2 This is the 3<sup>rd</sup> cohort of AI/AN SPNS grantees
- 3 AIDS cases up 25%
- 4 Co-morbidities also important, including mental health issues and STIs
- 5 Many located in rural areas, harder to link to resources

**Q:** Will funding be increasing for AIDS prevention & treatment?

**A:** We'll see what happens-there is a war.

**Q:** Are integrated service programs being developed?

**A:** We don't do as much as we should be doing but are working with CDC, Mental Health Substance Abuse Treatment Services, and Prisons on integration services. Some HRSA funding initiatives are supported by multiple agencies.

**Comment:** Thank you for not seeing low HIV statistics as being of low importance.

**A:** Low numbers are good and although absolute numbers may be low, the percent of the specific population affected often is high.

**Opening Prayer presented by Millard Lowery.**

**Introductions: Participants introduced themselves**

- Betty reviews issues of travel reimbursements - will provide forms to grantees on Friday morning for their signatures. Needs copy of their hotel receipt with a zero balance. Will be reimbursed 2-nights lodging, 3-days per diem, and ground transportation of \$20.00. It will take the University of Oklahoma approximately one week to process the reimbursement claims.
- Dr. Barney- Presented overview of what we want to accomplish at this grantees meeting. He introduced Dr. Huba of The Measurement Group who presented on "Use of Scales for Measurement"

**II. Dissemination: What Are We Learning and Who Needs to Know-(led by Lois Eldred, SPNS Branch Chief) - focus was on relevant audiences-AI/AN, substance**

**abuse treatment providers, mental health counselors, medical providers, government agencies, and others - that can learn from what you're doing-networks can be other Tribes, especially those in rural areas. Logic Model-what outcomes do you want to get out of this.**

- Betty -dissemination can be accomplished in a variety of ways. Some local activities include public service announcements in the local paper and radio. Many project attend conferences and could submit abstracts to present their model of services at those conferences, and the one that reaching our professional audiences are publications in professional journals. It becomes critical not only to implement services but also to demonstrate that our interventions were successful, then sharing that information through dissemination.
- In San Francisco, at the APHA Conference, we try to tell the story in as many different ways as possible-workshops, presentations, etc.
- Also can use the local paper to get the information out into the community. We can information community agency through presentations, meetings, and project flyers. It is important to target a variety of agencies including AA, NA, service providers including faith-based, rescue squads or anyone who has contact or works with high risk individuals.
- Not all dissemination needs to be outcome-based. Process evaluation is important information to share with the public because that is where you tell your story of what it took to implement your intervention.
- Need to partner with Primary Care so they [clients] can link with other needed services.
- **Problems with MDs**-doctor may not ask questions and only cover medical aspects of HIV.
- **IRB problems**: such as long travel and other barriers that need to be documented.
- HRSA has choices: could give you a dataset or could use the vast array of expertise that is represented in this group to come up with innovative practices such as an integrated holistic approach that could come out of the faith-based system.
- **Awareness issues**: Get folks to realize they won't get AIDS by touching someone with AIDS.
- More collaboration is needed between CDC and HRSA; also, how to present [HIV issues] to Tribal entities without offending Tribal taboos.
- **Dr. Eldred**: There's a ton of collaboration being done, but results are not translated to the field, therefore communities are not learning from these collaborations.
- Cost of HIV testing is prohibitive (especially in rural Alaska).
- Which audience is the most effective to educate-is it the Elders, clients or maybe providers?
- **Dr. Eldred**: Don't forget about qualitative aspect for identifying effective models; local characteristics; unique characteristics of your local population- need to note similarities and differences.
- Will that cause us to change our Logic Model, David?

- **Dr. Barney:** you do hear me push quantitative outcomes, but you do need to document problems, barriers; in the end its not how many miles someone had to travel, but how effective was your program-so its not one thing or the other but a balance of the two [quantitative/qualitative]. What role do you want the TA center to play?
- **Dr. Barney:** One point re: process evaluation-as Social Workers and service providers you are close to the process so it's harder to relate to outcomes.
- **Marguerite:** Outcome measures keep you targeted on where you're going and keep you from getting derailed or side-tracked.
- **Betty:** most of us are not researchers or evaluators so it's difficult to act as service providers and as evaluators-we thank you for your efforts.

### **III. Using Scales for Measurement (George Huba) - PowerPoint presentation: *Using Scales for Measurement in Evaluation Studies: A Very Brief Introduction***

- **Comment:** Language differences may exist for some constructs ("sad and blue" to describe depression).
- **A:** Yes, I agree-true on a number of constructs that's why it is important to use multiple questions to measure a construct.
- **Q:** What is the process for test validation?
- **A:** Out of 20 questions, use 4 or 5 that look pretty good-do a pilot test of 15- 20 respondents.
- **Q:** What if you want to change a measurement question 6 months later?
- **A:** You can add items pretty easily-you're better off with more items that are not perfect.
- **Dr Barney:** We don't want you to scale everything-however there are some things that are extremely important--an example is acculturation in the Border project--they decided to use 10 questions to measure this.
- **Dr Huba:** For this group, spirituality might be an important issue.
- **Comment:** Since each Tribe is different, it will be interesting to note commonalities and differences.
- **Betty:** What scales are being used?
- **A:** Quality of Life; Belief and Behavior.
- **Betty: Might want to create new scales in future.**
- **Dr Huba:** The 2 areas of concentration are 1) outcomes and 2) intake, where you characterize your clients in different ways.
- **Betty:** collecting demographic information is vital and maybe sensitive to ask among AI/AN-but remember although you may need a lot of information, you can ask for it gradually.
- **Comment:** It's important to make people comfortable first before asking for sensitive information.
- **A:** You can ask complicated questions by overlaying them with questions that will be asked by clinicians.

#### **IV. Client Intervention Documentation - Betty Duran - PowerPoint presentation handout: *Client Record Maintenance***

- **Q:** For community knowledge surveys, is written consent needed?  
**A:** It depends on what is asked-if its general knowledge of what services are available or if it is specific to the person being asked.
- **Comment:** We have a form from the health department that we use also.  
**A:** Yes, multi-disciplinary consent forms may be useful.
- **Comment:** We have applied for a certificate from HRSA so the courts cannot subpoena us for info provided by our clients.  
**A:** Dr Barney: the certificate of confidentiality does not relieve you of terra soft (SP) responsibilities.
- **Comment:** We use a combination of consent form and certificate of confidentiality.
- **Comment:** Also will need specific reference to HIV; we use a checklist.
- **Betty:** Also need to consider HIPPA regulations.
- **Q:** Regarding consent forms-most of case management is getting clients in for testing-at what point in engagement do we get the client to sign the consent form?  
**A:** We have a program where police bring in people off the street for detox- A lot of people get released the next day but for the people that stay 3-4 days and see a counselor, when the counselor sees “yes” to risk behavior questions, at that point we get them to sign a consent form.

**Betty:** you’re looking at how many times you talk to a person before they’re ready to get tested-as long as you are providing education you don’t need a consent form-but do maintain a contact log.

- **Q:** Can clinics test without their [client’s] knowledge or without a consent form?  
**A:** In some maternity clinics HIV prenatal testing is required.
- **Q:** What are the rules and regulations governing this--how do Tribal laws compare with state laws-if the woman denies testing at time of prenatal care, can we turn around and test the newborn?  
**A:** This is a huge issue--it depends on the state as well as Tribal policy.

#### **V. Project Report-Robeson Health Care Corporation - PowerPoint presentation and packets**

- **Q:** What does it mean when a client goes to a “Healing Lodge?”  
**A:** It is the outreach worker who would enroll the client.
- **Comment:** Context is important; on the client level, your program seems like a personalized approach .  
**A:** As of right now, we will have a lot of one-on one.
- **Q:** The Attitudes survey is really long, how is it going?  
**A:** [told how many clients had filled out form] The amount of time to fill out forms can be reduced if you use info from one form to fill out common items on other forms-it’s

important that folks don't wait-treatment slots can go away.

- **Q:** How long to complete pre-test?  
**A:** About 20 minutes.
- **Q:** How did you go about recruiting pastors-what was their response?  
**A:** We started last summer-whether we got the grant or not, we realized that community education was needed--its taken 6 months and we only got 16 people to participate.
- **Comment:** the timeline is great-it's also a theoretical model on pastoral training.  
**A:** The PNC3 will be after several modules of training-about mid-point in training we hope to be able to help them to develop their own instruments.
- **Q:** Is one of the outcomes that pastors will be able to refer?  
**A:** Yes we are training the pastors as well as the community-they will have been sensitized to the issues.
- **Q:** Dr. Huba: Seems like you don't quite have the behavioral items-you might ask for some very specific examples of steps they took.  
**A:** Or we might ask for a list of how many people they referred.
- **Q:** Dr. Huba: or ask what they have done differently.  
**Betty:** for qualitative items, make sure it stays simple and not too time consuming.
- **Q:** Regarding training of pastors--do you have a way of staying in touch or giving them ongoing support/training?  
**A:** We have monthly meetings-once pastors go out we want to bring them back to train future groups of pastors-also there is a major representative on the Board of Directors for each denomination.

**Betty introduced Wayne Sauseda, Director of Community Programs. Mr. Sauseda offered assistance and information with Title III: 1) Planning, 2) Capacity and 3) Early Intervention Grants.**

#### **VI. Project Report-Alaska Native Tribal Health Consortium - PowerPoint presentation and handout: *The Alaska Tribal Health Consortium's "Healthy Transitions Project"***

- **Q:** During the past 10 yrs in California there has been a move to put Alcohol and Drug (AOD) treatment programs into the prison system-is that happening in Alaska?  
**A:** No, all AOD treatment programs have been cut out of the prison system- the thinking being that their job is incarceration not rehabilitation-also budget cuts, stigma, lack of awareness regarding prisoners returning to their communities play into this thinking.
- **Comment:** Dr Barney: One comment is that your Goal 1 (cross sectional) is great; another comment is that Title III is not meant to provide health care to prisoners.  
**A:** This is meant to be transitional case management.
- **Q:** Are there any federal programs in your area?
- **Q:** Dr Huba-do you have access to findings from relevant SPNS projects in the past? There are 3 discharge planning projects in NY.

**VII. George Huba presentation on Sample Size - In introducing Huba, David briefly discussed the need for appropriate sample size and what that means for the evaluation of the programs.**

- One possibility to the small sample size is looking for more people.
- The issue is about how many cases we need to find the results 80 or 90% of the time.
- David reiterated that the smaller the sample, the more intense your intervention will need to be.
- **Q:** Is there a commonality on all sites for a data collection piece/item, so that we could reach the power better.  
**A:** No.
- George Huba stated that if you look at your expected final numbers, and realize that you can't reach an appropriate statistical power, then you need to look at alternative ways to adapt your plan to do so before you get to the end of the grant cycle. He suggested that you try and get to the mid-level.
- **Q:** Could we get there by changing the instruments.  
**A:** Absolutely, but it's more than changing instruments. You will need a large or medium effect size. There is a point where you're samples will just be too small.

You may need to explore qualitative methods.

- **Q:** Should we have an ideal of what we are looking for? Goal?  
**A:** If you are doing a quantitative instrument, shoot for large numbers. Use appropriate instruments, and make sure you get a good bang for your program.  
**A:** Suggest that in the next month, you talk with David about proposed numbers and the impact of those numbers.
- Katie said that at large numbers you will likely always find something significant, but you must make sure that it's clinically significant. You might want to look at qualitative if you don't have enough.
- George Huba stated that you should always have a qualitative running behind your quantitative. Case studies are one example. Staff interviews are another. Also, Focus groups with providers (system level).
- David stated that large numbers cover up a lot of mistakes.

## Native American Health Center Project Presentation

### *Handouts*

- 1 Chronologies
- 2 Strong Medicine newspaper
- 3 PowerPoint slides
- 4 Morning Star Rising compilation (Journal of psychoactive drugs)
- 5 2 PowerPoint slide (levels of treatment and circle of care)
- 6 Logic Model
- 7 Evaluation Research Questions

Unique aspect to this program is the nurse case manager's piece.

- **Q:** How do you separate activities for each of the programs that you are involved in?
- **A:** There is an overlap. These funds don't provide services. The different objectives for each funding source serve as our boundary. There is mutual respect among all workers and we have case conferences. We look at what's best for the clients.
- **A:** It is difficult to identify if this particular program initiated the change or if it was another one. It might be useful to identify what programs the clients are involved in. A notation in files that the client stating which programs they are accessing.

Millard remarked at the completeness of services under one roof. It's nice to not have to chase services.

- **Q:** Are you documenting the variations in service delivery (other funds).  
**A:** goal is to see if the coordinated system works. These are preliminary evaluation questions and we could explore the client questions deeper. Right now departmental charts are different, so we don't know who is accessing those different services at one time. Hope to centralize medical records and get a better picture of clients.
- **Comment:** You need to track doses of holistic services that clients get. They will likely respond to these covariates and it will impact outcomes.
- **Comment:** One stop shops are great, but it may not be effective in a rural setting b/c of confidentiality issues. Jennifer Olsen stated that we are looking for other options b/c of this reason. Ethan remarked that it's building a place where people feel good coming to. It's not about one-stop.

QOL instrument is from the medical outcomes and it works well with HIV. It measures health status. It may not be appropriate for questions 2 and 3. Ethan stated that it's only a first draft. Parousha stated that they are all linked.

George Huba identified that the QOL instrument has 7 sub scales, which measure different things.

Betty said that we would help review final measures as you develop them. At sites visits, we can review instruments and narrow down items.

### **NNAAPC Presentation - Alison Whitemore**

Reviewed examples of support from NNAAPC on working with projects.

- 1 Robeson: capacity building in community
- 2 SPIPA: working with you

Upcoming trainings available:

- 1 AETC (Mountain Plains) - NNAPC can pay for some conference related expenses. Email Alison with interest/intent.
- 2 Two-Spirit - who are they, and how to work with them. Also building networks of two-spirits. History, current issues, health and wellness. Full and partial scholarships available.
- 3 Another training emphasizes community tools on working with two-spirits and msm. Full and partial scholarships available.

Tools in the development process:

- 1 included in NNAAPC handout folder

Case Management Manual

- 2 on-line
- 3 created by native people
- 4 case management formally identified
- 5 very technical
- 6 Alison requesting feedback on how this would be helpful for SPNS projects, and possibly adapting it for each project. Make sure that it works for local staff

Millard Lowry suggested case management 101, then we can apply it to our native community.

Tracy said that we should be careful about what case management is. Medical? Social Service? It may be identified differently by different fields.

Alison reiterated that it is social service oriented.

Tracy gave the suggestion of separation of case management in rural setting v. urban setting.

Betty identified that a page of definitions will be needed Then explain rural v. urban. Other related definitions. Come up with generic model that can cross fields. Can add-on specifics. Define standards of care. Include gender/sex orientation definitions.

Parousha identified that they have a case management standards of care. It would be important to include a section on boundaries, particularly with natives.

Alison identified that the trainings will likely include thoughts, specific stories and ideas from current case managers.

Tracy reiterated that boundaries must be adapted for rural and urban settings. Tracey will share her definitions of rural with Alison. Melvin stated that are also working on rural issues.

Betty identified that Two-spirit is a regional term. Not universal native. Millard questioned if we are we moving in the right direction with two-spirits. Alison explained that it's an opportunity to bring the issue up. It's an opportunity to gain skills to carry into your communities. It's a way to support people and get them to start talking.

Parousha applauded the trainers sessions. Very specific trainings that help organize your work with the communities.

### **VIII. Project Report: Four Corners American Indian Circle of Services Collaborative - PowerPoint and hand-out presentation: *Integrating HIV, Substance Abuse and Mental Health Services at the Navajo Nation***

- **Q:** Is the Health Survey administered once? How long does it take?  
**A:** It depends on the language-if in English then about 1 hour-if not, up to 2 hrs or more-however, the surveys also can be done in 2 parts
- **Q:** Have you had a large number of clients that migrated to large cities?  
**A:** Of the 56 active cases, about half are mobile. Some are in the Phoenix area- and sometimes they're hard to track, so we work with other agencies
- **Comment (Richard):** one good thing is that you've got the data from the first phase- we want to make sure we get copies so we can talk about dissemination- in terms of what you've done from part 1 to part 2 it will be important to look at.
- **Dr Barney:** It's tough out there--Melvin has been the consistent voice for HIV- it's been tremendous how he has survived [politically]
- **Q:** Where do you start--does the case manager decide what is the primary service needed for each individual?  
**A:** This is a holistic model-people come in self-referred, from cities, etc-this is pretty fluid so it doesn't really matter where they start-the goal for each of us is to get the person in for treatment
- **Q:** (Millard): for example, I'm a new person I come to see you and I don't feel very

good, what happens next?

**A:** Where did you walk in?

**Response (Millard):** I walked into [his] office

**A:** Most entries are in to the Gallup agency. We do an assessment of what your needs are. We develop a care plan with you to address your needs--if you don't know your HIV status you can get testing there. Even if they [clients] know they're positive, about half the time they will not want case management because they want to be sure of confidentiality first--also many times they have not told anyone yet that they are HIV positive

- **Q:** What is your concept of what group is appropriate for Motivational Interviewing (MI)?

**A:** We want the doctors, case managers to be trained in MI

- **Q:** How did you come up with the 7 elements in the MI model?

**A:** It came out of the research

- **Comment:** We have somewhat of a similar model [circular]-you have to negotiate with the client--there's no one direction

- **A:** I like Millard's model--you just put them in a car and take them and actually we do the same--take them to the hospital--but they run away

- **Comment:** This has finally been a very consistent group of people to work with--Navajo

## **IX. Project Report: Yukon-Kuskokwim Health Corporation - PowerPoint presentation: *Circle of Care Project***

- **Q:** Has this [surveys for village leaders, providers, clients: belief, knowledge attitudes and belief] been analyzed?

**A:** We're still working on the specifics of data collection--but it [surveys] will come to me and Andrea. Our numbers are small--we're looking at 35-40 outreach clients--the number of HIV positive clients in our system is very small, but with the high number of Chlamydia infections, we feel the number of HIV positive is probably higher

- **Q:** How are you going to conduct the survey?  
**A:** Probably go into the community-it will be anonymous. Andrea: I'm working with community health representatives
- **Q:** Can we get a copy of the research design?  
**A:** Sure
- **Comment:** Dr Barney: it's a classic ANOVA design
- **Q:** How will you talk to Elders?  
**A:** There's a community curriculum
- **Tracey:** When you're working with Elders about HIV it's difficult for them to discuss. If you can associate HIV with what happened with TB then they will listen-HIV has so much stigma that its difficult for them to talk about
- **Mark:** Also, we've received Letters of Support from Elders

**X. Project Report: South Puget Intertribal Planning Agency - PowerPoint presentation: *Expanding the Circle of Care***

- **Q:** What do you do to increase knowledge level?  
**A:** For Teams we already started a curriculum of training--still to come is a 3 day training
- **Q:** What is the role of Tribal teams?  
**A:** By increasing their knowledge, their role is to increase knowledge among other systems. We already have done community dinners; had high school students do a poster contest for HIV; also, you can print media training
- **Q:** Question about where to get speakers?  
**A:** Also have Speakers Bureaus
- **Comment (Tracey)** Suggest you collaborate with Alaska folks  
**A:** Yes, that's a great idea

**Betty: The final item on our agenda is to plan for the next Grantees' meeting.**

- 1 Possible dates: November or early December
- 2 Locations: We try to hold meetings here (DC)
- 3 Maybe can piggyback with APHA meeting (Katey is moderator for APHA)

APHA is scheduled for November 15-19 in San Francisco-we could do a 1 day meeting right before APHA starts

- 1 The Chancellor Hotel in downtown SF has been very good about booking small groups
- 2 If we could hold it enough in advance of APHA (mid-October) then we could work out any problems that might come up
- 3 All would be willing to return to Washington DC [in mid-October]
- 4 Tentatively the 2<sup>nd</sup> or 3<sup>rd</sup> week in October

For 1 very long day? or 1 day and a half? or spread it out to relieve jet lag?

- 1 Agree on two 6-hour days, probably on a Thursday and Friday
- 2 Oct 9-10, unless there are previous commitments.

### **Recommendations:**

Kevin: I am kind of concerned, make sure we have protections of our clients, relatives as research participants. I hope everyone is applying for a certificate of confidentiality. Can we more than encourage people to protect records?

Sandi: Is that a training?

David: Everyone having to respond to HIPPA. Do we need HIPPA training from HRSA?

Kevin: I think we need common standards for the projects - certificate of confidentiality, separation of records etc.

Lois: Can you download off the internet?

David: HRSA can do a presentation on the Certificate and we can all fill one out during our next DC meeting.

Betty: I believe Kevin is suggesting that we set up standards of care requirements for the group as a whole. This is some thing that the group needs to discuss. Do we want to discuss it now? at our next meeting or monthly calls? Does everyone understand the certificate of confidentiality? Anyone else planning to apply?

Gloria: We have used it with all our prison projects.

Millard: I considered it but after talking with David, I decided we did not need it.

David: The certificate does not relieve you of professional requirements.

Ethan: I don't have enough information. If you can get us some information then I can consider

it.

David: There are links on the OU AIAN web page.

Betty: We can discuss during the next all grantees call with HRSA.

Tim: Could the appropriate HRSA representative be on the call?

Gloria: There was a death of a prisoner during one of our studies, our records were being reviewed to determine if could be subpoenaed. The Certificate of Confidentiality protected the project. The prisoner's wife was unaware of some of the information he had provided to the project.

David: The certificate could work against you as well.

Betty: Tim suggested we needed the appropriate HRSA representative to provide the information we needed to discuss.

Lois: The Certificate only protects you from illegal activities such as substance abuse, but not child abuse. It doesn't relieve you of those obligations.

Betty: On the next grantee's conference call we will coordinate with HRSA to have staff do a brief presentation on the Certificate of Confidentiality. Please review of web page.

Parousha: Could you email the link please?

**GRANTEE Conference Calls: (Betty)** Currently we are hosting a monthly all grantees call and individual grantee calls twice a month. I suggest that we continue with the monthly all grantee call and one individual project call in the middle of month. Who agrees? Betty would like the grantees to provide her with monthly project updates in bulleted format prior to the monthly all call meeting to be incorporated in the call minutes.

Pretty much unanimous approval. Betty will get with grantees and set up when the calls will occur for individuals projects.

Parousha: If you guys are not going to be on the call could you cancel or give us advance notice? We had some things we needed to discuss and were holding until the call.

Betty: Yes.

**CONFERENCES: (Mark)** Could you please elaborate on the conference in Savannah Georgia

Betty: OU has been invited to make a presentation and so has Millard. I will provide the web site link for registration information. It is not a required conference, it is up to you if you want to

decide whether or not to attend.

Parousha: Which conferences are required?

David: Nothing is required. We will talk about dissemination and try to come up with a plan. Presentations are much more powerful when we do them together.

**CONTINUATION APPLICATIONS: (Richard)** Program announcement: non-competing continuation applications due May 23<sup>rd</sup>. If you haven't received within the next week let your project officer know. I appreciate everyone coming out. Thanks to the project officers and OU team. Thanks to each and every one of the projects.

**Ethan:** Thought the conference went very smooth and was very valuable.

**Millard:** Closing prayer.