The WIPHL Word

Wisconsin Initiative to Promote Healthy Lifestyles

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The Director's Desk

WIPHL Funded to Test Depression Services

By Richard Brown, MD, MPH
Clinical Director

Good news! WIPHL has received funding to develop and test the effectiveness of screening, intervention, and referral services for depression, as provided by health educators without special mental health training. This effort is key in moving toward WIPHL's ultimate vision of offering a comprehensive, cost-efficient behavioral and mental health screening, intervention, and referral program for primary care settings.

Depression is the next logical clinical focus for WIPHL. At any given time, about 10% of primary care patients are suffering from depression. The prevalence is higher among people with alcohol and drug problems. Depression is associated with poor quality of life, disability, and high healthcare utilization. Depressed patients are at risk for suicide, other causes of mortality, and worse outcomes for chronic illnesses such as heart disease, lung disease, diabetes, and others. Studies have found that half of depressed primary care patients go undetected.

As of 2002, the U.S. Preventive Services Task Force has recommended universal depression screening in primary care settings, but only "in clinical practices that have systems in place to assure accurate diagnosis, effective treatment, and follow-up." Some WIPHL clinics are already screening for depression, but most are not. Studies have shown that it is difficult for primary care providers to respond to positive depression screens, as the average provider, according to research by the UW Department of Family Medicine's Dr. John Beasley, is already addressing three clinical problems in 15 minutes for the average patient.

WIPHL will study whether health educators can feasibly and effectively provide depression intervention and referral services along with similar services for risky and problem drinking and drug use. Through the one-year project, we will design service delivery protocols, train clinic staff and health educators to administer the services, provide the services, and collect follow-up data from participating patients.

Collaborating clinics will include the Amery Regional Medical Center, the Aurora Mayfair Clinic, the Aurora Sinai Family Care Center, Mercy Clinic South, and St. Joseph's Family Clinics. Other key collaborators will include Terri Woods, PhD, of the UW Department of Psychiatry; David J. Katzelnick, MD, of the Madison-based Healthcare Technology Systems; Mental Health America–Wisconsin; and Ken Kushner, PhD, Mark Marnocha, PhD, and Marie Roethlisberger, MD, of the UW Department of Family Medicine.

Funding will be provided by the UW School of Medicine and Public Health's Institute for Clinical and Translational Research (ICTR). ICTR supports type 2 translational research, which studies how to apply prior research findings, such as those on the effectiveness of depression screening and treatment, to practical ways to improve health—which is what WIPHL is all about.

Call In to Statewide Conference

If you can't make it to our statewide conference April 10-11, you can participate in one of the highlights by teleconference. On **Friday, April 11, 10:55-11:55,** WIPHL clinical director Rich Brown will speak about "Contracting for Year 3—Incentivizing Service Delivery at Sustainable Levels." In the third year of WIPHL grant funding, we aim for the project to take a giant leap toward financial sustainability. All funded clinics will provide SBIRT services at levels that will generate substantial financial offsets for program operation when reimbursement is available. At this session, we will begin discussing possible clinic funding mechanisms that will serve as incentives for providing services at sustainable levels.

You can phone in at 1-800-462-1257, passcode 0826, conference name WIPHL.

Health Educator Update

Spring Brings New Health Educators

By Laura A. Saunders

Spring is here and budding health educators are plentiful. This month, we welcome 10 new health educators to our crew, making for large, lovely bouquet—two dozen, to be exact.

The new health educators, like their pioneering WIPHL HE colleagues, come to us with varying experience and educational backgrounds. All are enthusiastic learners who are excited to be a part of this program. They see the challenges and are ready to face them. What follows are details about who they are and their thoughts about WIPHL. I encourage all of us to think about how we might be helpful to a new HE who is learning the ropes.

Alice Spann, BSW: Alice comes with a wealth of social work experience, from child welfare to serving those with chronic and persistent mental illnesses. She currently works as a social worker and intake specialist for the Behavioral Health Clinic at **Milwaukee Health Services, Inc.**

Diana B. Manning, MSW: Diana has worked in health education management and social work in hospitals, community health clinics, and state agencies. The patients she has served are system-involved due to domestic violence, child abuse, and other health concerns. Diana will be delivering WIPHL health services in addition to other responsibilities at the **Burnett County Department of Health, Human Services, and Aging.**

Christine Casselman-Erickson, MA: Chris, a new hire for **Aurora Sinai,** has a master's degree in medical sociology. She also comes with a wealth of experience as a volunteer in the areas of education and spiritual community.

Susan Bush, MA: Susan, the health educator at **Aurora Mayfair,** has a master's degree in clinical psychology. Her clinical experience includes working with adults who have PTSD, depression, anxiety, and adjustment disorders, and with children who have autism.

Emerald "Emmie" Hauser, AODA Associate: Emmie gained AODA experience while working at Winnebago Mental Health as an AODA intern working with adults and as a teacher's assistant working with adolescents. She is brand new to her position at **ThedaCare.**

Thelma "CeCe" Mitchell: CeCe came to WIPHL in a most exciting way. Not knowing that she was being considered for the position at the **St. Croix Tribal Clinic,** CeCe was asked what was needed at the clinic to make this program work. Ironically, she described herself! CeCe brings a wealth of community knowledge to this program. Through her life experience and her current work as the clinic's information specialist, she has gained an appreciation for what motivates people in her community and what kind of support they need to make changes.

Anne Heath, BS: Anne was trained as a community health educator. Her current work at the **Scenic Bluffs Community Health Center** focuses on community health outreach and patient education.

Melissa Barth, BS (2008): Melissa is currently an intern at **Family Health/La Clinica.** Melissa's experience includes training and coaching for individuals seeking to make behavior changes.

Amber Sedivy, BS: Amber's undergraduate degree is in health promotion and wellness. In her pre-WIPHL life she served in the U.S. Air Force. Her internships have included personal training, cardiac rehabilitation, and occupational health. Amber will work at the **St. Croix Regional Medical Center.**

Dan Scoville, BS: Dan has a degree in human services with an emphasis on mental illness, domestic violence, developmental disabilities, and stress management and relaxation. Prior to his new position at **ThedaCare,** Dan worked as a volunteer coordinator at a local shelter for people seeking refuge from domestic violence.

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Here's what the new HEs said when asked what excites them about WIPHL:

• The nonjudgmental approach

• Getting patients to think about change and see that they CAN make changes

• Bringing this program to our area

• Bringing a new service to patients who are predominantly underserved in all realms

• The "MI" way of being with patients

• Being proactive about helping people with AODA problems before they get worse

• Positioning the program in general medical clinics reduces stigma

• Offer more comprehensive health screens to patients

• "Helping people make lifestyle changes that will improve their health is my passion!"

When asked what challenges they anticipate, they said:

• Getting EVERYONE at my clinic on board

• Gaining trust and respect at my clinic

• Getting proficient in use of the tablet to serve patients, especially in making the words fluid and seeming like my own

• Implementing this program in a public health setting

• Getting the flow right for our clinic

And here's an important question for all of us—how can the WIPHL coordinating center, clinic staff, and the more seasoned HEs help the new HEs overcome barriers? Here's what the new HEs said:

• Have a mentor

• Visit other clinics to observe flow

• Be available for questions

• Share stories about successes and bumps in the road

• Personal attention from clinic managers, especially on Day One

Welcome aboard, new HEs! Please know that everybody involved in WIPHL is eager to help you succeed in your work—and even have a good time along the way.

Meet the New Clinics

The latest clinic additions to the WIPHL fold represent a diverse range of medical settings in Wisconsin. There's the **Scenic Bluffs Community Health Center** in Cashton, which opened 15 years ago when local business owners teamed with the Wisconsin Primary Health Care Association to open a clinic offering low cost health care. It remains strongly community-based and serves many patients whose fees are adjusted for their income. Services under one roof include basic medical care, dental care, optometry, chiropractic care, and a pharmacy. There's **Milwaukee Health Services, Inc. (MHSI),** a federally qualified community health center that operates at two sites on Milwaukee's North Side but provides a range of primary health care services to patients from all over the county, regardless of income. On the other end of the size scale, WIPHL welcomes clinics in Wonewoc and Hillsboro that are part of **Gundersen Lutheran,** a not-for-profit health care network that spans three states, 19 counties, and employs some 7,000 people. We add to our Aurora partnership with **Aurora Health Center Mayfair,** located in Wauwatosa. And now, north of Polk, we welcome the **Burnett County Department of Health, Human Services, and Aging,** based in Siren.

And that's not all. In the next newsletter we will provide more information about WIPHL services with **ThedaCare,** a community health system in the greater Fox Valley that includes four hospitals and is the third-largest health care employer in Wisconsin.

We are pleased that WIPHL is being embraced by these clinics and look forward to becoming a part of the communities they serve.

Cultural Competence Update

Moving Toward Statewide Standards

By Harold Gates

I would like to dedicate this month's column to Milt McPike (1939-2008) who passed away on Saturday, March 29. He was an extraordinary leader as principal of Madison East High School for 23 years. He not only touched the lives of countless students and staff members, but the life of the larger community as well.Until recently he was a member of the University of Wisconsin System Board of Regents. Milt's legacy will include the fact that the essence of all of his work and life was grounded in cultural competence.

This past month also saw a great deal of movement in cultural competence on the state level as being the driving force behind the work of the State Council on Alcohol and Other Drug Abuse Council (SCAODA). The committee is chaired by state senator Carol Roessler. There was a motion put forth by the SCAODA Diversity Subcommittee which reads as follows:

> The State Council endorses the use of the National Standards on Culturally and Linguistically Appropriate Services (CLAS) by organizations in their efforts to move toward a more culturally competent model of care.

This is a major step forward for the committee, which, after months of education and lobbying by subcommittee chair Michael Waupoose, will set the tone for SCAODA and all of its subcommittees' future work. The body of work adopted—the Standards for Culturally and Linguistically Appropriate Services (CLAS)—was put forth by the U.S. Department of Health and Human Services and developed by its Office of Minority Services. These standards will assist SCAODA in gearding its work to be aligned with what I predict will become nationals standards for all organizations receiving government funding. The CLAS standards already have been adopted by a number of organizations and have been cross-walked with Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards. That body accredits all major medical facilities and organizations in the United States.

Because these standards are so important, we wish to share them here. Please feel free to contact me with any questions at Harold.Gates@fammed.wisc.edu or (608) 265-4032.

National Standards on Culturally and Linguistically Appropriate Services (CLAS)

The collective set of Culturally and Linguistically Appropriate Services (CLAS) mandates, guidelines, and recommendations issued by the U.S. Department of Health and Human Services Office of Minority Health are intended to inform, guide, and facilitate required and recommended practices related to culturally and linguistically appropriate health services (National Standards for Culturally and Linguistically Appropriate Services in Health Care Final Report, OMH, 2001).

The CLAS standards are primarily directed at health care organizations; however, individual providers also are encouraged to use the standards to make their practices more culturally and linguistically accessible. The principles and activities of culturally and linguistically appropriate services should be integrated throughout an organization and undertaken in partnership with the communities being served.

The 14 standards are organized by themes:

Culturally Competent Care (Standards 1-3)

Language Access Services (Standards 4-7)

Organizational Supports for Cultural Competence (Standards 8-14)

Within this framework, there are three types of standards of varying stringency: mandates, guidelines, and recommendations as follows:

CLAS **mandates** are current Federal requirements for all recipients of Federal funds (Standards 4, 5, 6, and 7).

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CLAS **guidelines** are activities recommended by OMH for adoption as mandates by Federal, State, and national accrediting agencies (Standards 1, 2, 3, 8, 9, 10, 11, 12, and 13).

CLAS **recommendations** are suggested by OMH for voluntary adoption by health care organizations (Standard 14).

Standard 1: Health care organizations should ensure that patients/consumers receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.

Standard 2: Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.

Standard 3: Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.

Standard 4: Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.

Standard 5: Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.

Standard 6: Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).

Standard 7: Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

Standard 8: Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.

Standard 9: Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.

Standard 10: Health care organizations should ensure that data on the individual patient/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and are periodically updated.

Standard 11: Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.

Standard 12: Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.

Standard 13: Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.

Standard 14: Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.

For more information, visit:

- National Standards on Culturally and Linguistically Appropriate Services (CLAS) in Health Care (Final Report): http://www.omhrc.gov/assets/pdf/checked/finalreport.pdf
- National Standards for Culturally and Linguistically Appropriate Services in Health Care (Executive Summary): http://www.omhrc.gov/assets/pdf/checked/executive.pdf
- Normas nacionales para servicios cultural y lingüísticamente apropiados en la atención sanitaria (Resumen ejecutivo): http://www.omhrc.gov/assets/pdf/checked/spanishexeSum.PDF
- Cultural Competency Site: http://www.omhrc.gov/templates/browse.aspx?lvl=1&lvlID=3

Treatment Liaison Update

Getting Treatment: An Insider's View

By Mia Croyle

For people struggling with addiction, the decision to seek treatment can be lifesaving. That is what motivates me every day—knowing that I am working with a program that helps people make life-altering changes. The patients that I work with have often taken the difficult first step: deciding to seek treatment. Unfortunately, the next step—figuring out how to pay for it—often proves equally challenging.

Many of the patients who are referred to the treatment liaison have health insurance. That should make getting necessary treatment easier, right? Well ... not really. Insurance companies are less likely to provide coverage for substance abuse treatment than for treatment for physical health care needs. When coverage is provided, substance abuse benefit packages typically have higher deductibles, higher co-payments, and greater out-of-pocket maximums for the patient to pay. Additionally, there are often more restrictive day and visit limits than for physical health care needs. Finally, insurance companies are more likely to have lower annual and lifetime dollar limits on coverage for substance abuse services than for physical health care needs.

What does all of this mean? The bottom line is that even patients who are employed and insured are less likely to be able to afford addiction treatment than other necessary medical care. That is why so many professionals in our field see the need for legislation that mandates comprehensive parity in health care coverage.

In the meantime, an important part of my work with patients who are insured involves helping them communicate with their insurance companies so that they understand their coverage and are able to fully utilize their benefits. WIPHL's treatment funds can be used to bridge the gap between the cost of treatment and the amount covered by the patient's insurance. An example of this is in Dane County, where a patient recently completed intensive residential treatment at the Teresa McGovern Center using a combination of his private insurance coverage and WIPHL treatment funds. It was gratifying to be able to work as an advocate for the patient and to collaborate with the county AODA coordinator, the treatment facility, and the insurance provider to get the needed service.

For patients who are uninsured, the process is a little different in that I work with the patient and the county system to help them to get assessed for eligibility for county-funded treatment. I have had patients access intensive outpatient and residential treatment programs through county funding. WIPHL treatment funds have been used to pay for treatment when county funds are not available.

All of these efforts do bear results! In the month of March we had 10 new referrals to the treatment liaison and three patients enter treatment. This brings our total for WIPHL since March 2007—our first year of operation—to 104 referrals to treatment and 32 patients entering treatment. Now that we have things up and running more smoothly, we can reasonably expect these numbers to increase. This is all thanks to the hard and fruitful work of our participating clinics and health educators out in the field. Please know that your efforts are saving lives.

March 2008
Month End Data

Clinics	Eligible for BS*	Completed BS	% BS Completed	Positive BS	% Positive BS	Completed FS	% FS Completed
Wave 1							
Augusta	89	40	45%	18	45%	8	44%
Eau Claire	233	73	31%	30	41%	21	70%
Northeast	319	230	72%	66	29%	68	103%
Polk County	N/A	63	N/A	29	46%	18	62%
St. Joseph's	310	285	92%	81	28%	61	75%
Wingra	28	24	86%	11	46%	12	109%
Totals	*979*	*715*		*235*	*33%*	*188*	*80%*
Wave 2							
Amery	N/A	114	N/A	35	31%	19	54%
Clear Lake	N/A	4	N/A	1	25%	0	0%
Luck	N/A	14	N/A	2	14%	1	50%
FamHlt/LaCl. (0.5 FTE)	93	91	98%	25	27%	19	76%
Menominee	228	184	81%	94	51%	33	35%
Totals	*321*	*407*		*157*	*39%*	*72*	*46%*
Wave 3							
Mercy Clinic South	285	117	41%	32	27%	15	47%
Walker's Point	261	234	90%	54	23%	36	67%
Waukesha	326	189	58%	73	39%	47	64%
Totals	*872*	*540*	*62%*	*159*	*29%*	*98*	*62%*
Wave 4							
Minocqua	142	123	87%	38	31%	19	50%
St. Luke's	174	94	54%	32	34%	21	66%
Totals	*316*	*217*	*69%*	*70*	*32%*	*40*	*57%*
Grand Totals	**2,488**	**1,879**		**621**	*33%*	**398**	*64%*

*Eligibility varies by clinic

Clinic Corner/QI Commentary

By Lilly Irvin-Vitela

QI Tip—Comparing progress from a previous month to current accomplishments is a way to monitor implementation strategies. Has there been a change in outcomes? Are a greater or fewer number of patients being screened for alcohol and drug risk? Are those who self-report risk more or less able to meet with the health educator than in previous months to receive services?

As a program, more patients received WIPHL services in March than February. Of the reporting clinics, an average of 75% of eligible patients completed the brief screen in March. This is a slight decrease from February when the average number of patients completing the brief screen was 80% across the project. In March, the brief screen rates ranged from 31% completion of brief screens to 98% completion of brief screens. On balance, it's important to recognize that in aggregate the brief screening goals were met in both February and March.

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Why does this matter? We know that the prevalence of risk related to alcohol and drugs is high. We know that screening, brief intervention, and referral to treatment is a proven way to help patients reduce their risks associated with alcohol and drugs. Brief screening is a way to ask everyone who is eligible about their risks. Health educators cannot respond to a risk that they don't know about.

As a program, 64% of patients were able to receive SBIRT services in March. This was a 1% increase from February. Although our program as a whole is not meeting the goal of 75% of patients who screen positive meeting with and receiving services from the health educator, this data is helpful. It points to opportunities for quality improvement. Clinics are engaged in several strategies to increase the likelihood that a patient who screens positive will meet with and receive care from the health educator.

Please read on to learn more about what is happening with participating sites all around the state.

Wave 1 Clinic Highlights

• Lisa Cory provides health education services at UW Eau Claire and the Augusta clinics. February to March at Augusta showed a drop in the percentage of patients who completed the brief screen. The percentage of patients that screened positive for risk at Augusta and met with the health educator remained constant at 44% from February to March. Lisa was able to deliver services to four more people at Augusta from February to March. Lisa was also working hard with the team at Eau Claire. Although fewer people were screened in general and fewer people screened positive for AODA risk, Lisa was able to meet with 70% of the people that screened positive. This is a 22% increase in the number of patients who reported a risk and had an opportunity to learn more about their risk and explore opportunities for behavior change.

• Christina Lightbourn and the team at UW Northeast—The incredible front desk staff at Northeast did it again! In March, 230 people completed the brief screen, that is, 72% of eligible patients. The team at Northeast has a system in place for brief screening that works well. Furthermore, Christina and the nursing staff have a great process for connecting patients who screen positive with services at the same visit. Consequently, Christina meets with all of her patients face-to-face. The phone work that Christina does with patients is always as follow-up to face-to-face visits. In February, 67% of the patients who screened positive were able to receive care from Christina. In March, 103% of patients who screened positive received services. Christina also manages a list of patients who screened positive in the past but were unable to connect with her. She uses the list to flag patients that are returning to the clinic so that she can provide health education services to them. In this way, Northeast was able to connect with over 100% of eligible patients in March. (To hear about how well this system serves patients, please don't forget to read The Last Word at the end of this newsletter.)

• Terry Murphy continues to work with the team at Polk County. In March, 64 people completed the brief screen. This is consistent with the 63 people who completed the brief screen in February. Way to identify eligible patients and get brief screens completed! Terry and the team at Polk County were also able to provide services to 18 of the 29, 62% of people who screened positive on the brief screen. Although there are natural ebbs and flows, Terry was able to provide health education to a significant number of people primarily over the telephone.

• The three clinics in the St. Joseph's system—Elroy, Wonewoc, and Hillsboro—were able to complete the brief screen with 92% of eligible patients. 285 people were able to reflect on and self-report about their level of risk on the brief screen. This is very consistent with the success experienced in February when 91% of patients—281 people—completed the brief screen. The front desk staff at Elroy, Wonewoc, and Hillsboro have a lot to be proud of. More impressive still, they've accomplished this in light of a recent clinic move at Hillsboro and an involved electronic medical record conversion process. This success is mirrored by an excellent active hand-off process and coordination across three clinics. Sue delivers services with a mixture of face-to-face and phone. She was able to deliver services to 61 of the 81 patients who screened positive. That is 75% of eligible patients! St Joe's continues to meet and exceed quality improvement goals in order to ensure quality patient care and a normalization of dealing with alcohol and drug risks in a proactive and consistent way!

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• Julia Yates and the providers at UW Wingra continue to use the shadowing method. This method requires close coordination between Julia and providers and allows Julia to better respond to the complex needs for which the clinic is brief screening, including violence and depression. In February, 40% of people who were eligible were brief screened. In March, 86% of people who were eligible completed the brief screen. Given this shadowing method, Julia was able to deliver services to all of the patients who screened positive in addition to a patient who screened positive in the past, making the percentage of people who received a brief intervention over 100%. This is a 24% increase from February.

Wave 2 Clinic Highlights

• Mary Boe and the team at Amery Regional Medical Center and Clear Lake and Luck were able to brief screen 142 people in February and 132 people in March. They are consistent in their brief screening process. The nursing/MA staff have made great efforts to screen patients. In terms of delivering services to patients who have screened positive, Mary gets a combination of active and inactive hand-offs. This results in some services being delivered face-to-face and some services being delivered over the telephone. In February and March, from 60-54% of patients who self-identified alcohol and/or drug risk received services. Although it is often more challenging to connect with patients via telephone, whether Mary is delivering services face-to-face or over the phone she is able to engage patients in the health education services and deliver excellent patient care.

• Zella Van Natta and the team at Family Health La Clinica brief screened 98% of eligible patients in March. This is consistent with the 100% of people who completed the brief screen in February. The staff at the front desk consistently set the bar for meeting and exceeding this quality improvement target. This means that patients can count on being asked about their alcohol and drug use at least once a year. The medical assistants/nursing staff have also made consistent progress in the active hand-off process to connect Zella with patients in need of health education services. In February, 61% of patients who screened positive received care from Zella. In March, 75% of patients received WIPHL services. In delivering services to two additional patients, the team at La Clinica was able to meet their quality improvement goals and, more importantly, help patients take stock of their drinking and/or drug use and consider a healthier lifestyle.

• The nurses at Menominee Tribal Health Clinic and Diane Carlson continue to exceed WIPHL targets for brief screening. In February, 80% of eligible patients completed the brief screen. In March, 81% of patients completed the brief screen. Although the percentage of full screens that are completed in response to a positive screen remains below targets, Diane is delivering services to a high quantity of patients. For example, in February Diane saw 30 new patients and in March she saw 33 new patients. Diane delivers services both face-to-face and by phone, and, as others who rely on telephone service delivery have experienced, there are challenges in reaching patients. Once Diane reaches people via telephone, she is able to work successfully with patients and has very few refusals to discuss alcohol and drug risk behavior and explore opportunities for behavior change.

• St. Croix Regional Medical Center has a new health educator, Amber Sedivy, who is currently in training and will resume service delivery this spring.

• The St. Croix Tribal Health Clinic at Hertel has a new health educator. Thelma “CeCe” Mitchell has worked at Hertel and will begin relaunching WIPHL and delivering services this spring.

Wave 3 Clinic Highlights

• Mercy Clinic South—Carrie Buchen and the team at Mercy began trying something new in their brief screening approach in March. They are doing a combination of screening at the front desk and screening by nurses/medical assistants for particular providers. Twenty-four additional people were screened in March compared to February. Carrie delivers all initial services face-to-face. In February and March, Carrie has been able to meet with 50% of patients who report risky drinking or drug use.

• Aurora Sinai Family Care Center and Aurora Sinai Internal Medicine have hired a new health educator, Christine “Chris” Casselman-Erickson. Chris is currently in training and the team at Sinai will relaunch services this spring.

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• Terrific things are happening at Walker's Point. Staff and providers at Aurora Walker's Point alongside Ruth Perez successfully delivered face-to-face WIPHL services to 36 patients in March. This is 11 more new patients than in February. Ruth enthusiastically reported that all members of the team are taking an active role in creating access for patients to health education services. This enthusiasm is evidenced in the numbers of people who have been brief screened. In February, 180 eligible patients were screened. In March, 234 patients were screened. Walker's Point met and exceeded the brief screening goals in March, which means that more patients were able to benefit from health education services. The streamlined process for WIPHL service delivery has resulted in greater collaboration and greater access and quality of care around alcohol and drug use for patients.

• Betzaida Silva-Rydz and the team at Waukesha Family Practice Center continue to make great strides. In February, 125 people were brief screened. This was 46% of eligible patients. In March, 189 patients completed the brief screen. This was 58% of eligible patients. This indicates that the strategies being used to systematically brief screen are yielding progress. As a result a greater number of people are being identified who need services and Betsy was able to meet with 47 patients in March. This is 15 more patients than in February. Betsy systematically meets with the majority of patients face-to-face due to the engagement and support of nursing staff at Waukesha. Other members of the team are also taking an active role in putting patients in touch with Betsy. In fact, at the time of the site visit in early March, a patient checking out turned in a WIPHL brief screen to a staff member. The opportunity was not missed, and the team member contacted Betsy to let her know that there was a patient at the desk who had screened positive. Betsy was able to meet with the patient.

Wave 4 Clinic Highlights

• At Marshfield Clinic Minocqua Center, Kerri Weberg and the team members continue to excel in their brief screening process. The percentage of patients who were screened in March was 87% compared to 71% in February. The percentage of patients who self-reported risk and received WIPHL services increased 3% in March. QI changes that are currently in process suggest that the percentage of patients who receive services will continue to grow.

• Aurora St. Luke's and Wendi Rusch—94 people received the brief screen in March. This was 54% of eligible patients compared to 61% of patients in February. However, the actual number of individuals who received a screen increased by 16 people. There was a higher prevalence of positive screens in March compared to February and although Wendi was able to deliver services to more people, there was a greater number of people who self-identified risk but did not receive services. Wendi and the team with St. Luke's continue to fine-tune the QI process to connect patients with the great services that Wendi is available to provide.

WIPHL People

She's a familiar face in a new position. We are pleased to announce that **Jessica Wipperfurth** has been promoted to Quality Improvement Data Analyst Specialist. Her duties will include providing quality improvement technical assistance, assisting the executive team with data analysis, and supporting the clinical director with grant submission and reporting. We congratulate Jessica on her new position and are certain she will remain indispensable! Look for news about the person who will fill her former position in the next edition of The WIPHL Word.

The Last Word

Gratitude

From a clinic in southcentral Wisconsin

A patient in his mid-40s who had been drinking since his late teens came to a primary health clinic. In addition to drinking four or more drinks a day, he was a longtime crack user. Although for years he had restricted his use to weekends, he was now spiraling up to using four or five days a week. The patient filled out the WIPHL brief screen and told his physician that he was eager to undergo treatment. The physician immediately connected the patient with the WIPHL health educator.

The health educator informed him that getting into treatment can be a complex process (see Treatment Liaison Update, page 6, for more on this subject) and could take some time, particularly since his insurance coverage was highly restricted. The patient remained undaunted and visited the health educator twice during the waiting period, on one occasion to do the decisional balance and on another to talk about options he could immediately pursue, such as Alcoholics Anonymous.

Through the efforts of the health educator and WIPHL treatment liaison Mia Croyle, who worked with other agencies and organizations to get needed funding, the patient entered and successfully completed a 30-day residential treatment program.

Every day in group discussion, patients were asked to think and talk about the positive things in their lives, the things for which they were grateful. This patient had a long list—but each and every day, he specifically named both the WIPHL health educator and treatment liaison.

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