The WIPHL Word
Wisconsin Initiative to Promote Healthy Lifestyles

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The Director's Desk

Medicare barriers to reimbursement for SBIRT may fall

By Richard L. Brown, MD, MPH
Clinical Director

During what might prove to be our nation's hottest summer on record, support for SBIRT has also continued to heat up. The latest good news for SBIRT, as well as tobacco and depression screening and intervention, comes from the US Department of Health and Human Services' draft strategic plan, which you can find at: http://www.nih.gov/about/director/budgetrequest/plan_fy10_15.pdf.

One of DHHS' five major goals in the next five years is "Transform Health Care." Six objectives focus on making healthcare coverage more secure and accessible, improving healthcare quality and safety, reducing costs and enhancing the value of healthcare, ensuring access for vulnerable populations, promoting the adoption of health information technology, and, of special relevance to us: "Emphasize primary and preventive care linked with community prevention services."

Strategies for emphasizing preventive care include: "Remove financial barriers to accessing recommended preventive health services by providing health insurance that includes coverage of these services at no cost to the patient." Tobacco, alcohol and depression screening and intervention are targeted, as the US Preventive Services Task Force has ranked them as Grade A and B preventive services.

Another is: "Ensure the delivery of recommended evidence-based preventive screenings and services with no co-payment, through all public and private health plans." While healthcare reform has already started moving us in this direction, this is the first indication from DHHS that Medicare barriers to reimbursement for SBIRT will fall. As some of you know, we've been concerned that sliding scale fees have been deterring community health center patients from benefiting from SBIRT services. In case there's any doubt that DHHS intends to address this, another strategy is: "Increase the emphasis of Community Health Centers on providing preventive services and linking with the public health community."

Of course, the details of this strategy have not yet been worked out, but the proposed goals and objectives provide a solid springboard for advocacy and strong reason for optimism.

An important rationale for this strategy comes from the kind of data projects like ours have been generating—data that show it's feasible to deliver SBIRT services in busy healthcare settings, and it's effective!

So thanks very much for your continued outstanding work delivering SBIRT services in Wisconsin. We are making a difference, for our patients and for the expanding numbers of individuals, families and communities across the US who will soon benefit from behavioral screening and intervention.

Project Manager Update

UW Population Health Institute releases report on WIPHL outcomes and SBIRT services

By Candace Peterson, PhD

Recently, the University of Wisconsin Population Health Institute (UWPHI) and the WIPHL program prepared reports for each of our WIPHL clinical site partners, providing both clinic-specific information and overall program performance and outcome information. Most significantly, the outcome data to date indicates that participation in the WIPHL program leads to substantial decreases in individuals' use of alcohol and other drugs.

One section of the report compares overall intake and follow-up data, based on data from brief screens completed by patients; full screens based on health educator interventions with patients; and follow-up interviews conducted five to eight months after intake. There are too few follow-up cases at most clinics to include any clinic-specific follow-up results at this time, but the overall results are very encouraging.

WIPHL is currently providing SBIRT services in 15 clinical settings, including 10 primary care clinics, 3 federally qualified health centers (FQHC), 1 emergency department, and 1 trauma and other inpatient unit. From March 2007 through early May 2010 more than 86,000 patients have completed brief screens across all clinical sites. Of the positive brief screens, 17,580 full screens have been completed with the following results:

- 66% had a risk severity of at-risk;
- 6% had a risk severity of harmful;
- 9% had a risk severity of likely dependent; and
- 19% had a risk severity of low risk.

The follow-up data demonstrate positive changes in reducing the use of alcohol and marijuana in SBIRT participants. Some of the most notable changes include:

- A 20 percentage point decrease in binge drinking among females under age 65;
- A 15 percentage point decrease in binge drinking among males under age 65;

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- An average decrease of 3.3 drinks for the maximum number of drinks consumed on a given day among those with a risk severity of likely dependent;
- An overall reduction in the number of days alcohol was used in the past 30 days; and
- A five percentage point decrease in marijuana use in the past three months.

The data also show that the work being done by health educators in WIPHL clinics is important to the people they see. The data show that 65% of follow-up participants reported that the WIPHL program helped them to change or modify their lifestyle. Of those who made changes, 94% of respondents indicated that they were currently working on continuing these changes at the time of the follow-up interview.

The other section of the report contains clinic-specific data, comparing a clinical site's overall clinic population demographics to demographics of those patients who received SBIRT services at the clinical site. The intent of this comparison is to offer our clinical sites information they can use to identify and help address any possible disparities in SBIRT service delivery. For example, there may be a disparity in providing brief screens to those 25-34 years of age at a clinical site. This is the purpose of evaluation—to obtain good information, address issues, and make changes to improve the quality of the program.

On one hand, while in theory it was a good idea to use a clinical site's overall population as a baseline for comparison with the site's WIPHL patient screening data, there were

Project Manager Update

UWPHI report *continued*

limitations to this analysis. First, the demographic information for those receiving SBIRT services was generated by our WIPHL tablets, on which we collect demographic data for the government GPRA data set. The way that clinical sites collect demographic data in some cases did not match the way that demographic data are collected on the tablets, e.g, difference in race or age categories. This makes it hard to compare apples to apples.

Second, in some WIPHL clinical sites, SBIRT services are offered to only a subset of the site's patients; again, this makes it difficult to do a valid comparison. For example, a site may screen only those patients who are having a physical exam, yet the clinical population represents everyone. The data from this site would indicate that there may be a disparity in the number of males receiving a brief screen (less males than females), but this may just be a result of more females having physical exams.

On the other hand, despite these limitations, these comparisons were not developed to grade our clinical sites or to evaluate the work of health educators. They were developed to start the conversation about possible disparities that could exist in the site.

We expect these reports will provide our clinical sites and our WIPHL partners around the state with useful information and analysis. The data can be shared to address the need to provide SBIRT services on a larger scale.

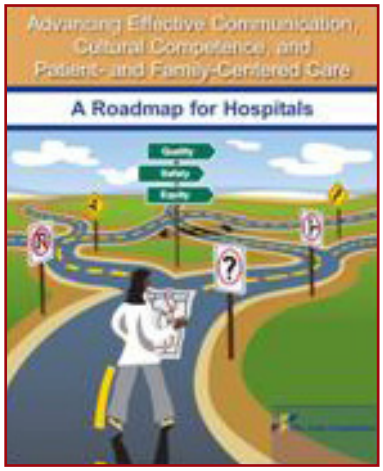
We plan to update these reports in the future. If you have any questions or suggestions for additional analyses, please contact Robin Lecoanet at the Population Health Institute at rlmoskowitz@wisc.edu

Cultural Competence Update

'Roadmap for Hospitals' key to high quality care

By Harold Gates MSSW, CISW
Associate Director of Cultural Competence

"We want to inspire hospitals to integrate effective communication, cultural competence, and patient- and family-centered care into their organizations," says Dr. Schyve. "By giving hospitals this Roadmap, we are providing them with the methods to begin or improve upon their efforts to ensure that all patients receive the same high quality care". The above statement is included in the news release sent out by the Joint Commission on August 4, 2010. The news release rolled out a free monograph which contains the elements of the quote list above. This project was directed by Paul Schyve, M.D. and other staff at the Joint Commission.



The *Roadmap for Hospitals* does not cover every aspect of the key issues listed above, but represents what hospitals and other health care organizations should consider if they aim to meet the unique needs of each patient. Practical examples and recommendations address various issues and hospitals and health care organizations are encouraged to adopt a combination of the practices discussed in the monograph and use these examples as a foundation for creating processes, policies, and programs that work best for their particular organization. The *Roadmap for Hospitals* contains information for compliance with upcoming patient-centered communication standards targeted for 2012, and prepare organizations for future accreditation decisions (i.e., cultural competence). To access the complete text of the *Roadmap for Hospitals,* visit The Joint Commission website at www.jointcommission.org

In July, I attended the Georgetown University Training Institutes 2010 and gathered some useful information. Institute # 4 entitled, "Modifying Evidenced Based Practices to Increase Cultural and Linguistic Competence" was very eye opening. A team of presenters from The Nathan Kline Institute for Psychiatric Research, Center of Excellence in Culturally Competent Mental Health instructed attendees on *A Toolkit for Modifying Evidence-Based Practices to Increase Cultural and Linguistic Competence.* They discussed the need to modify EBPs for the following reasons:

1) There is a need for effective mental health/substance abuse interventions for cultural groups.

2) SAMHSA's registry of EBPs includes a growing list of effective interventions.

3) There is no systematic method for considering modifications to EBPs for cultural groups.

I found this institute useful, because of the assumption that there is an identified need for services in the cultural community. Community outreach is conducted throughout the modification process and this makes it different from other types of EBP modifications. The toolkit can be found at the following website: http://ssrdqst.rfmh.org/cecc/. There you will find an interactive PDF document that contains the instrument, and an accompanying workbook that guides you through the modification process.

Month end data

Year 4 Month 11
July 15 – August 14, 2010

Clinics	*Eligible for BS**	*Completed BS*	*% BS Completed*	*Positive BS*	*% BS Positive*	*Completed FS*	*% FS Completed*
Aurora Sinai Family Care Center (0.9 FTE)	91	76	83.5%	26	34.2%	56	215.4%
Aurora Sinai Women's Health Center (0.9 FTE) **	161	122	75.8%	35	28.7%	32	91.4%
Aurora Walker's Point (0.9 FTE)	167	167	100.0%	68	40.7%	57	83.8%
Beloit Area Community Health Center	190	190	100.0%	42	22.1%	48	114.3%
Columbia St. Mary's	166	160	96.4%	66	41.3%	61	92.4%
Family Health/ La Clinica (0.5 FTE)	156	154	98.7%	34	22.1%	11	32.4%
Gundersen Lutheran Family Medicine	307	283	92.2%	95	33.6%	50	52.6%
Gundersen Lutheran Trauma Center	88	n/a	n/a	n/a	n/a	84	95.5%
Menominee Tribal Clinic	210	168	80.0%	60	35.7%	61	101.7%
Milwaukee Health Services, Inc. (0.3 FTE)	17	3	17.6%	1	33.3%	1	100.0%
Northeast Family Medical Center	215	180	83.7%	57	31.7%	55	96.5%
Scenic Bluff's Community Health Center (0.2 FTE)	19	19	100.0%	7	36.8%	3	42.9%
St. Joseph's Community Health Services - Adolescents	7	7	100.0%	1	14.3%	0	0.0%
St. Joseph's Community Health Services - Adults **	96	68	70.8%	16	23.5%	11	68.8%
Upland Hills Health	125	115	92.0%	26	22.6%	12	46.2%
Waukesha Family Practice Center	176	170	96.6%	54	31.8%	47	87.0%
Grand Totals	**2,191**	**1,882**	**85.9%**	**588**	**31.2%**	**589**	**100.2%**

*Eligibility varies by clinic
**Data incomplete as of press time

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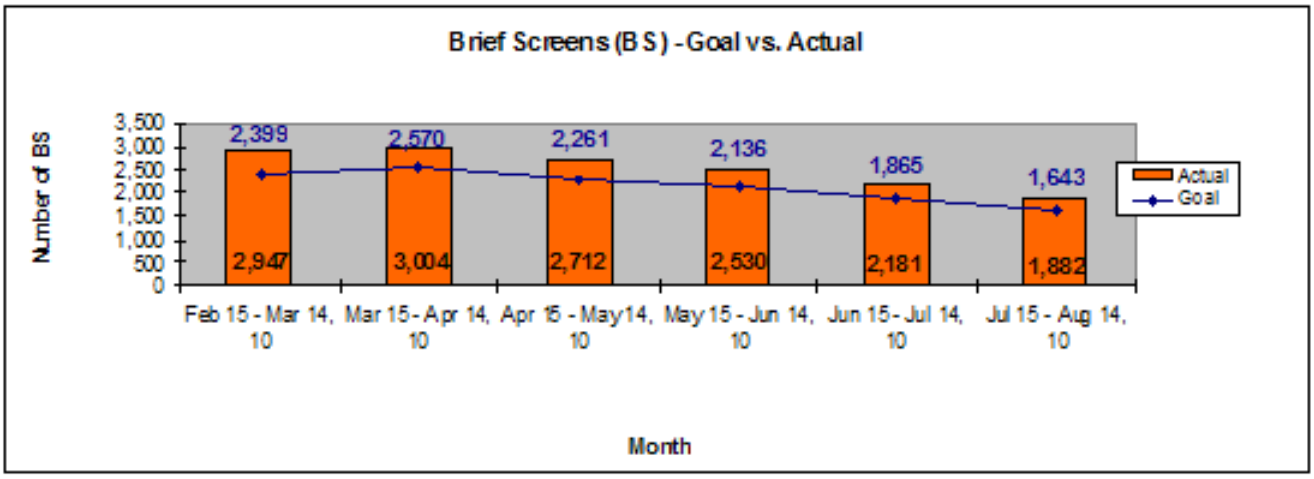
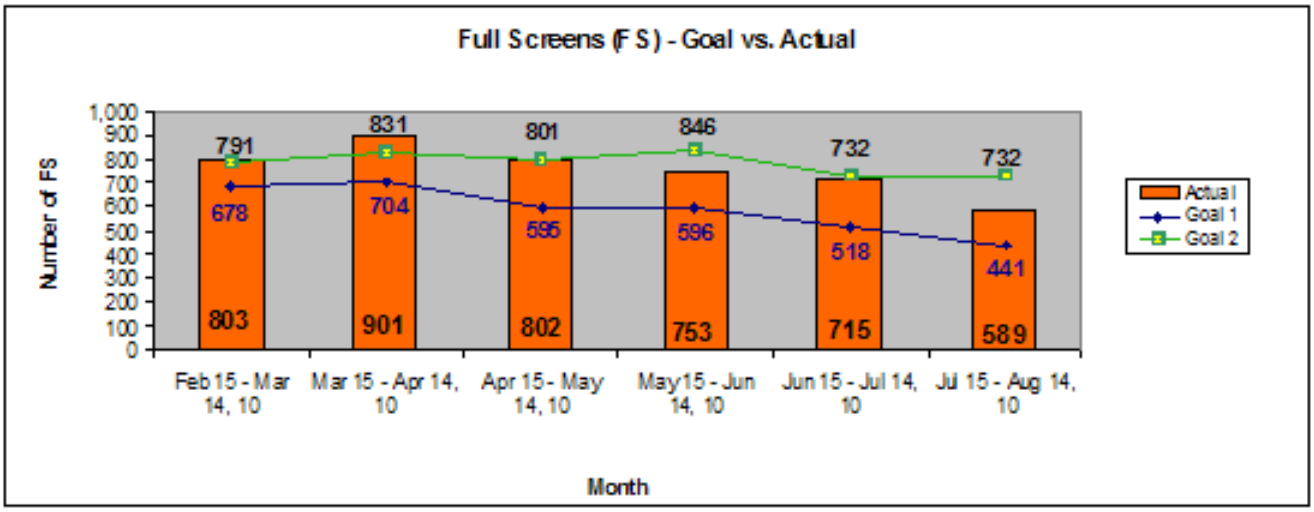
6 month wrap-up



Actual: Number of brief screens completed
Goal: Brief screen 75% of eligible patients



Actual: Number of full screens completed
Goal 1: Year 4 (Sept 15, 2009 - Sept 14, 2010) - Full screen 75% of patients who brief screen positive
Goal 2: Year 4 (Sept 15, 2009 - Sept. 14, 2010) - Number varies by site based on start date

Access to SBIRT Update

WIPHL HE's and teens gather in Wausau, WI

Laura A. Saunders, Mia Croyle

The WIPHL health educators gathered at the Jefferson Street Inn in Wausau for our 4th annual summer retreat. We gathered for camaraderie and a chance to share successes and woes about the unique challenges presented to WIPHL health educators. The main item on our agenda was to enhance motivational interviewing (MI) skills and expand their confidence in serving adolescent patients.

In teams of three, the health educators kicked off the retreat by reviewing an assigned adolescent developmental or psychosocial task and listed how it might manifest in an adolescent. They presented their results to the larger group. They then went on to match the components of MI spirit, skills and strategies to what we know about adolescents and how they are in the world. The picture shows one of the posters and the considerable thought that went into each topic. The result was a resounding—MI is especially well suited for use with adolescents.

The current tablet system will not be configured to serve this population. Instead, health educators were trained to use paper and pencil guides. The entire afternoon of Day One was spent familiarizing the HE's with these protocols.

This practice put them in a good place for using them with some guest adolescents on the morning of Day Two. Four teenagers, who are currently in recovery from alcohol and or drug misuse, joined us for some practice rounds with our protocols.

The teens were very receptive to the protocols. They told us that they appreciated not feeling judged, they weren't bombarded with questions and they felt like the health educators were trying to understand them. Later as panelists, telling us their own stories of use and recovery, they admitted that being asked about their use in their own primary care settings would have been helpful and they would have been truthful.

We're eager to support the WIPHL health educators in delivering services to this important segment of population.

The Last Word

I Can See Clearly Now

At a follow-up visit for his recent eye surgery, a patient indicated that he remembered talking to the clinic's HE the year before and he wanted to see her again. In the meeting with the health educators the patient who was not previously ready for change now had a long list of things he wanted to do—with his new eyesight and WITHOUT alcohol. He's started treatment and will hopefully, "take advantage of life" soon.

The WIPHL Word The WIPHL Word is the monthly newsletter of WIPHL, the Wisconsin Initiative to Promote Healthy Lifestyles, an SBIRT program funded by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA), administered by the Wisconsin Department of Health Services (DHS), and coordinated by the University of Wisconsin School of Medicine and Public Health (Department of Family Medicine) and the Wisconsin Medical Society. Readers are encouraged to send suggestions and submissions to our new editor, Steve Baillies, at steve.baillies@wismed.org.