The WIPHL Word

Wisconsin Initiative to Promote Healthy Lifestyles

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The Director's Desk

Health Care Reform, Recession, and SBIRT

By Richard L. Brown, MD, MPH
Clinical Director

While headlines on health care reform continue to focus on federal legislation, the health care scene continues to evolve at all levels.

One recent example at the national level is the federal parity bill. Passed on October 3, 2008, the bill eradicates limits on mental health and substance abuse reimbursement that exceed reimbursement limits on other health care services. The bill takes effect for most health plans on the first day of their new plan year after October 2, 2009. For many plans in Wisconsin, including Medicaid, that means January 1, 2010. Unfortunately, with resources already stretched, Medicaid is so far expanding access to psychiatric care but not other care such as psychotherapy and addiction consultations. There has been a groundswell of concern about this. Stay tuned.

An exciting state-level example of possible reform is a proposed parity bill in Wisconsin. The federal parity bill applies to health care groups of at least 50 individuals. The Wisconsin Legislature is considering a bill that would extend parity to governmental health plans and smaller commercial health care groups. This would expand parity to many other Wisconsinites.

A sad local example of change has occurred in Milwaukee. Having suffered a substantial loss of grant funding, Milwaukee County has ceased admitting patients into county-funded substance abuse treatment. The County is instead offering less expensive wraparound services, which clearly are not sufficient treatment for alcoholism or drug addiction. Stay tuned on this development as well.

Most Wisconsinites—both experts and the general public—agree that expanding treatment for mental health, alcohol, and drug disorders is the right thing to do. It's also the smart thing to do, because when those disorders go untreated, spending increases elsewhere in both the public and private sectors. It is tragic that access to these services is being curtailed by the recession, when many people need them the most. It's especially frustrating because research has suggested that such services ultimately will save money.

A bright spot in health care continues to be SBIRT. Nationally and here in Wisconsin, despite the recession, movement toward funding SBIRT services continues to accelerate. Health plans want to do good by their subscribers, and SBIRT gives them return on investment within 12 months. Dean Health Plan is now the twelfth major Wisconsin health plan to reimburse for SBIRT services, as of January 1. And, as we have previously reported, Medicaid expands reimbursement to all its recipients starting January 1.

While national, state, and local developments in health care may seem out of our control, SBIRT remains one way we can make a difference. We can continue to be a shining example of a systems change that benefits everyone—patients, their families, our communities, health care plans, and health care purchasers.

As we approach the holidays and the coming year—a key turning point for SBIRT sustainability—I'd like to thank everyone who continues to make SBIRT an expanding reality in Wisconsin. Regardless of what happens in federal, state, and local government, together we are making a difference here in Wisconsin! Happy holidays and a happy New Year to everyone!

For more on the benefits of addiction treatment, see Mia Croyle's article on page 4.

Project Manager Update

WIPHL's Big Rocks

By Candace Peterson, Ph.D

Here is a well-traveled story popularized by author Stephen Covey*:

One day a speaker was addressing a group of business people about productivity, and to illustrate a point, he set a two-gallon glass jar on the table. Then he placed about a dozen fist-sized rocks one at a time into the jar. When the jar was filled to the top, he asked, "Is this jar full?" Everyone said, "Yes."

Then he said, "Really?" He pulled out a bucket of gravel, dumped some into the jar, and shook it so that the bits of gravel worked down between the big rocks. He asked the group again, "Is the jar full?" By this time they were on to him. "Probably not," one of them answered. "Good!" he replied. He reached under the table, brought out a bucket of sand, and dumped sand into the jar. It went into all of the spaces left between the rocks and the gravel. Then he grabbed a pitcher of water and poured until the jar was filled to the brim.

"What is the point of this illustration?" he asked the audience. One go-getter said, "No matter how full your schedule is, if you try really hard you can always fit in more!"

"A fair interpretation," the speaker replied, "but maybe there's another lesson." The speaker emptied the jar and asked an attendee to fill it again, instructing him to put the big rocks in last. No matter how hard he tried, the rocks wouldn't fit.

The truth imparted by this illustration is: If you don't put the big rocks in first, you'll never get them in at all.

Over the last several months, WIPHL has engaged in a process of identifying our "big rocks," and then using them to prioritize efforts and clarify team and individual roles and tasks. We have been driven by a desire to determine what was most important for us and to make our decisions based on those very important criteria. We want to bring our priorities to life. Here, then, are WIPHL's "big rocks":

Rock I: Consistently deliver efficient, high-quality SBIRT services

Build and maintain internal capacity to develop, monitor, support and track state-of-the-art service delivery in clinical sites. Build clinical site capacity to deliver quality SBIRT services.

Rock 2: Maintain WIPHL infrastructure and meet grant requirements

Meet service delivery and follow-up target number, oversee evaluation of grant process and activities, and provide required documentation of project status. Ensure alignment among organization's mission, goals and objectives, and individuals' responsibilities within that framework (strategic planning and team work planning). Develop, oversee, and maintain necessary contracts, budgets, HR systems, data systems, and equipment/supplies.

Rock 3: Make behavioral prevention services routine in Wisconsin health care settings. (Growth and sustainability.)

Build demand and support for SBIRT through supporting: capacity for external service delivery; financing to support implementation of behavioral prevention services; widespread WIPHL implementation.

The story of the jar imparts life lessons as well. If you know what matters to you, what the next key step is toward an important long-range goal, do that first—and then there will be time, energy, and space for everything else.

What are your big rocks? Your loved ones? Your education? A worthy cause? As a new year begins, think of the "big rocks" in your life, and use them to help you make this a healthier and happier year for yourself and others.

**Watch a six-minute video of Stephen Covey's "Put the Big Rocks in First" at http://video.google.com/videoplay?docid=-357998200076562861#*

Clinic Services Update

Supporting Our Sites

By Laura Saunders

Everyone at WIPHL central plays a role in serving our clinical sites. The primary responsibility for supporting the health educators (HEs) and their sites falls to the Site Operations Team. This is a big job, but we're fortunate to have the largest internal team. While we tend to cross-cover for each other frequently, our major roles are: Mia Croyle, treatment liaison and QI lead; Celeste Hunter, MI feedback and coaching; Trisha Neklewicz, tape transcription; Laura Saunders, clinic communications and site operations oversight. We've been doing some work planning for the remainder of Year 4 and we thought it would be useful to share some of the major tasks we complete, often behind the scenes, in service of supporting our HEs and WIPHL sites.

At present we have 20 HEs across the state. They are serving patients in primary care clinics, free clinics, FQHCs, behavioral health, inpatient, and emergency room settings.

MI feedback and coaching: Per contract requirements, all HEs must submit one audiotaped session per month for review. While we've heard from HEs that this is NOT their favorite task, we ask for those tapes because we have no other way to monitor what goes on between patients and HEs. Recently we've started scoring the tapes according to the MITI (Motivational Interviewing Treatment Integrity, pronounced "mighty") scale. This instrument is a well-validated tool for measuring adherence to the principles of MI. The breakdown of the categories on the MITI provides us with the information we need to coach the HEs in specific areas needing improvement; likewise, we can cheer them on in areas of strength. We're currently working on finalizing our criteria for HEs to "graduate" to less frequent taping and coaching. We will continue to require tapes even after graduation because we know that MI skills tend to drift without some kind of monitoring.

Initial and ongoing training: We organize and conduct all initial and ongoing training. HEs are in unique positions at their clinical sites. While there may be other ancillary staff, the health educator is the only person at the site who has the unique challenges that come with delivering SBIRT services. Our ongoing training activities provide technical assistance, information sharing, training and skill development, and updates. Additionally, the weekly group calls, one-on-one monthly calls, and retreats are intended to bridge that gap and make the HEs feel like part of a larger group.

QI reports and site feedback: Sites receive a monthly data report detailing adherence to their contract deliverables, including number and percentage of patients brief-screened, number and percentage of patients full-screened, HE performance and skill measures, and sustainability efforts. These reports are important parts of the feedback loop between the coordinating center, health educators, and WIPHL sites. It is our intention that these reports are useful tools for sites to monitor their progress, identify areas in need of improvement, and highlight successes. These monthly reports then trigger the quarterly corrective action process whereby sites that have not yet achieved their targets as specified in the contracts come up with formal plans to improve in those areas. This can be a point where technical assistance needs are identified and we can provide more intensive individualized quality improvement support.

In the New Year, along with all of our usual support activities, we'll be rolling out the requirements for HE graduation to less frequent tape review and developing new forms and procedures for clinics enrolling in WIPHL.

How can we best serve YOU? Please let us know! You can reach me at laura.saunders@fammed.wisc.edu, 608-262-6519.

Access to SBIRT Services Update

Addiction Treatment Saves Lives and Money

By Mia Croyle

Health care reform is all over the news these days. So is the economy. On the treatment front, most of the news isn't good. Budget deficits are resulting in decreased funding for addiction treatment services for the uninsured or underinsured at the exact time when people who were previously covered are losing that coverage due to job loss or the inability to pay skyrocketing premiums. And even before our economic disaster, only one in 10 Americans affected by addiction were receiving treatment.

But as a Chinese proverb states, in the midst of every crisis is an opportunity.

A white paper from the Closing the Addiction Treatment Gap initiative entitled "Unforeseen Benefits: Addiction Treatment Reduces Health Care Costs," shows that providing treatment to Americans suffering from an addiction to alcohol and drugs will lead to substantial health care savings totaling billions of dollars over a decade. The paper cites studies showing that addiction treatment will help to decrease emergency room visits and shorten hospital stays as well as reduce the complications associated with addiction's effects on chronic illnesses and other conditions.

We've seen this with our WIPHL patients. Anecdotally I know of several patients with chronic health conditions that were very poorly controlled when they entered treatment and who are now managing their conditions much more effectively. It's heartwarming to hear of the individual patient who is now able to manage his heart condition, keep her blood sugar levels under control, or adhere to a treatment regimen for his Hepatitis C. It's also encouraging to look at the larger system and appreciate the savings our nation could realize if effective treatment were made affordable for all Americans who need it.

As the paper from Closing the Addiction Treatment Gap concludes, "Health care reform presents a unique opportunity. As part of this national discussion, addiction treatment should not be regarded as a burden on our health care system. Instead it is a solution—a solution that will help make health reform affordable. Every dimension of health care reform—comparative effectiveness research, information technology infrastructure, and coverage of the uninsured—should include addiction treatment to help contain costs and achieve the goals of better quality health care."

To read the entire paper, go to www.treatmentgap.org.

For more on this subject, see Rich Brown's article on page 1.

Cultural Competence Update

The Evolution of Cultural Competence at WIPHL

By Harold Gates

I inevitably find December a good month in which to reflect on what has transpired since the beginning of the year. And I have to say it has been anything but quiet. We are still grappling with health care reform on the national level, but on the state level we are moving ahead with coverage of SBIRT services by Medicaid. President Obama picked up his Nobel Peace prize a few days ago. We are still wondering if he will pull off health care reform, much less end the war in Afghanistan. This is a time of major transitions on all levels. And much closer to home, we have experienced great change in the way we are infusing cultural competence in the infrastructure here at WIPHL.

Most recently we were involved in dialogue around the executive summary of a cultural competence organizational assessment. The assessment was carried out by Kevin Browne, Ph.D., who is a principal consultant with Inter-Source Consulting and an associate of the Midwest Center for Cultural Competence. He shared his observations with us regarding the strengths and areas of improvement to consider at the WIPHL Coordinating Center. We are in the process of sorting out priorities that will be folded into our overall strategic planning, which we have been working on since the beginning of the year with management consultant Barb Hummel. The work of both of these consultants will be put into Year 4 staff work plans. The Cultural Competence Steering Committee will also be called upon to give input into this process, since the committee was revamped earlier this year and has been instrumental in establishing a Cultural Competence Work Plan. That plan emphasized our organizational efforts in four main areas: 1) Service Delivery; 2) Staff/Team Development; 3) Organizational Environment; and 4) Community Relationships. The coming together of all of these efforts will assist us in setting short- and long-term goals for the coming year.

The second area of emphasis for our cultural competence transition this past year has been in continuing education and training for WIPHL health educators. Our most recent HE cultural competence teleconference was on sexual orientation, which explored a sub-module of the California Brief Multicultural Competence Scale (CBMCS) Participant Workbook. We continue to use this as one element of continuing education. We also recently held Wave VIII training for the four new health educators who were featured in last month's WIPHL Word. We will be exploring other relevant topics for future HE teleconferences and retreats.

Finally, work has begun with one of our clinics that expressed interest in a cultural competence organizational self-assessment. We will be doing follow-up on those efforts into the new year and share our findings. Our work on cultural competence in the coming year will be informed by the work that we have put into strategic planning this year, and it will be exciting to experience continuing progress in 2010. I wish everyone happy holidays and continued success with our WIPHL/SBIRT initiative. If you need technical assistance in your cultural competence efforts, you can reach me by e-mail at Harold.Gates@fammed.wisc.edu or (608) 265-4032.

Month End Data

Year 4 Month 3
November 15–December 15, 2009

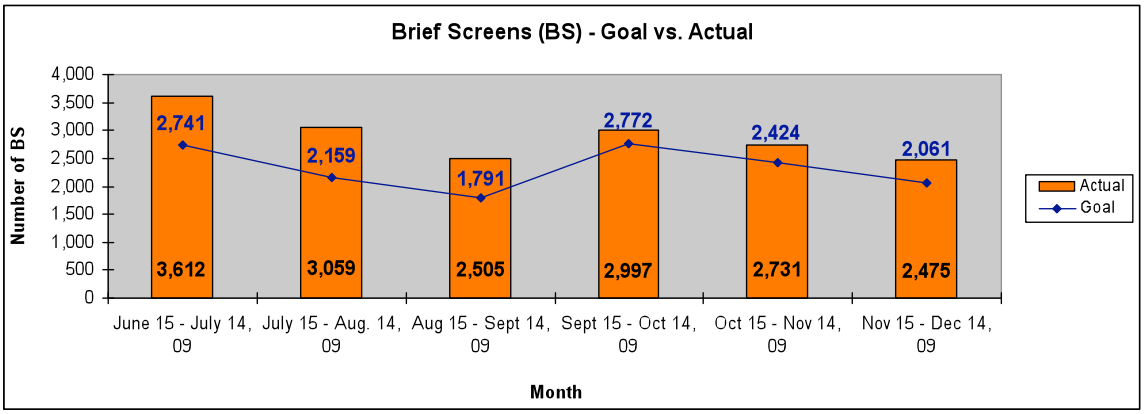
Clinics	*Eligible for BS**	*Completed BS*	*% BS Completed*	*Positive BS*	*% BS Positive*	*Completed FS*	*% FS Completed*
Amery Regional Medical Center	161	150	93.2%	60	40.0%	45	75.0%
Aurora Family Care Center	135	122	90.4%	41	33.6%	40	97.6%
Aurora Sinai Women's Health Center	154	135	87.7%	35	25.9%	44	125.7%
Aurora Walker's Point	211	209	99.1%	70	33.5%	66	94.3%
Beloit Area Community Health Center	322	306	95.0%	87	28.4%	76	87.4%
Columbia St. Mary's	102	102	100.0%	42	41.2%	25	59.5%
Dean East	183	178	97.3%	72	40.4%	71	98.6%
Family Health/ La Clinica (0.5 FTE)	111	111	100.0%	30	27.0%	30	100.0%
Gundersen Lutheran Family Medicine	231	189	81.8%	53	28.0%	28	52.8%
Gundersen Lutheran Trauma Center	17	n/a	n/a	n/a	n/a	14	82.4%
Marshfield - Minocqua Center	241	225	93.4%	59	26.2%	45	76.3%
Menominee Tribal Clinic	507	394	77.7%	90	22.8%	73	81.1%
Milwaukee Health Services, Inc. (0.3 FTE)	3	3	100.0%	1	33.3%	0	0.0%
Scenic Bluffs Community Health Center (0.2 FTE)	20	20	100.0%	6	30.0%	0	0.0%
St. Joseph's Community Health Services - Adults	76	76	100.0%	15	19.7%	11	73.3%
St. Joseph's Community Health Services - Adolescents	9	9	100.0%	1	11.1%	1	100.0%
Upland Hills Health	41	41	100.0%	13	31.7%	11	84.6%
Waukesha Family Practice Center	241	205	85.1%	65	31.7%	50	76.9%
Grand Totals	**2,748**	**2,475**	**90.1%**	**740**	**29.9%**	**616**	**83.2%**

*Eligibility varies by clinic
UW Health–Northeast not included

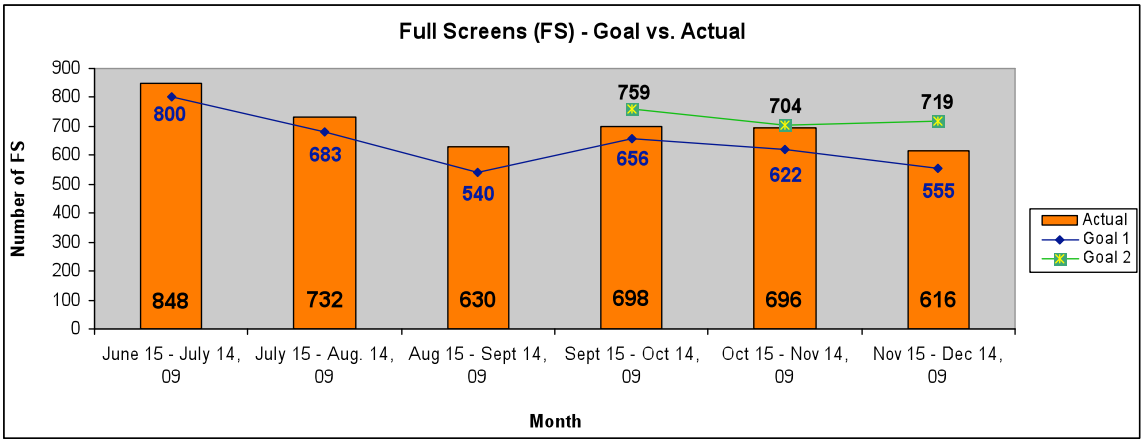
Data in this and accompanying chart complied by William Merrick

Continues on next page

Six-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) - P4P Clinics: Full screen 75% of patients who brief screen positive
Goal 2, Year 4 Quarter 1 (Sept 15 - Dec 14 2009) - Number varies based on clinic start date

B&R Webinars: Lessons Learned

It's wonderful that SBIRT services are being covered by more and more health plans—but billing and reimbursing for those services does involve a learning curve.

Luckily we're able to offer help, and we plan to refine our materials and techniques over the coming year. In November and December, WIPHL offered an initial series of webinars conducted by a noted master in the field, Penny Osmon of the Wisconsin Medical Society. All materials are viewable on the WIPHL website (www.wiphl.com) under a newly established Billing & Reimbursement navigation tab.

"Penny Osmon did a fabulous job of collating a tremendous amount of intricate, complex information into three hours of presentation," notes WIPHL clinical director Rich Brown, MD, MPH. But the material was a little daunting. "Hearing the presentations underscored for me the need to develop an easy way to organize the information for billing and clinical staff at our clinical sites."

Brown and Osmon will be working on tables and/or flow sheets so that sites can access the information they need in a logical, convenient manner, says Brown.

In other words, WIPHL's working on it, with the goal of making billing and reimbursement as simple as possible. Stay tuned for more info!

The Last Word

Opting for abstinence

From a health educator in southcentral Wisconsin

A 58-year-old male patient filled out his brief screen. In years past when his physician had asked him about his alcohol use, he'd stated that he had one to two drinks per day, which for men is within "low risk" guidelines. But more recently his alcohol use had dramatically increased to six to seven drinks per day. The patient had not identified any negative consequences related to this and didn't feel his use was impacting his health.

During our conversation we discussed his use along with potential future health risks to which he was possibly exposing himself. The patient was surprised to hear the ways in which alcohol might impact his health. At that visit he expressed interest in making changes in his alcohol use and participated in two follow-up sessions in the following weeks.

While working with me, the patient's lab results came back from his visit with his physician and there were abnormal values that needed to be addressed. When the patient realized his alcohol use may have been contributing to those results, he decided that, rather than just cut back down to low-risk guidelines, he would stop drinking altogether. He was able to do this successfully, as per his report in a telephone follow-up. The patient now says he is alcohol-free.

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