The WIPHL Word

Wisconsin Initiative to Promote Healthy Lifestyles

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The Director's Desk

Healthcare Reform, Health Homes and Behavioral Screening and Intervention

Richard Brown, MD
WIPHL Project Director

Yet another aspect of healthcare reform that few individuals have heard much about is "health homes." This is how Congress refers to what many other organizations have been calling "medical homes"—a term that may eventually disappear, in part because many Americans confuse it with "nursing homes."

Health homes are healthcare settings that replace episodic care based on illnesses and patients' complaints with coordinated, acute, chronic, preventive and end-of-life care, which emphasizes long-term therapeutic relationships. Healthcare reform law provides for a federal program whereby state Medicaid programs:

- Develop new standards for health homes, with federal guidance and approval
- Establish ways to recognize healthcare settings that meet those standards
- Receive 90% federal reimbursement over two years for healthcare services delivered to eligible patients in healthcare homes

That hefty federal reimbursement will serve as a huge incentive for Medicaid programs to establish health home programs.

Eligible patients must have two chronic conditions or one chronic condition and risk for another or one serious and persistent mental illness. Eligible chronic conditions are substance use disorders, asthma, diabetes, heart disease, and overweight—having a body mass index of more than 25, which includes over 70% of US adults.

Will binge drinking qualify as a risk factor for a chronic illness? If so, that will include 30% of Wisconsin adults. These are the kind of details that will need to be worked out.

So, how is this relevant to WIPHL? In their applications for health home programs, Medicaid programs must specify how their health home patients will receive "access to preventive and health promotion services, including prevention of mental illness and substance use disorders." In addition, Medicaid programs must consult with WIPHL's funding agency, SAMHSA, on how health homes will "insure access to a wide range of physical health, mental health and substance use prevention, treatment and recovery services." Screening and intervention services will, no doubt, be part of this service continuum.

This is yet another way that tobacco, alcohol, drug and depression screening and intervention services will be integrated into the fabric of healthcare. This is one more reason we should all be proud of how we're helping to set an example of the kind of care that will soon be standard across the nation.

Thanks, everyone, for all you do in partnership with WIPHL to improve healthcare for your patients. And have a very happy holiday season.

Project Manager Update

More on SBIRT Sustainability

Candace Peterson, Ph.D.
WIPHL Project Manager

We'd like to share some important news related to billing and reimbursement for delivery of SBIRT services.

WIPHL staff have been working hard to help make sustainability of SBIRT services – without grant funding- a reality. Our efforts have centered on:

- building knowledge and developing resources for increasing the clinical sites' capacity to bill for these services; and
- building support and demand for SBIRT services, delivered in clinical settings by experienced health educators, with payers and purchasers in Wisconsin.

WIPHL recently asked our clinical site partners to help us gather information about claims they submit to payers, and resulting status of those claims. We've asked them to:

- convey to us detailed information about an SBIRT claim submitted to a third party payer;
- report to us a payer's decision on a claim;
- report the decision on an appealed claim;
- submit information on past claims that payers have already acted on, dating back as far as January 1, 2010; and
- track site costs associated with delivering SBIRT services.

This week, our clinical site managers, HEs and clinical site billing staff at our clinical partner sites attended a webinar facilitated by Dr. Rich Brown, WIPHL Project Director, to get the details of how the process works. Over the next few weeks, Steve Baillies (IT WIPHL) will be talking with each clinical site's billing staff to set up an individualized plan for completing and submitting billing/reimbursement information to WIPHL.

In the final year of WIPHL's 5 year federal SBIRT grant, getting information from our clinical partners about SBIRT claims submitted to third party payers is an important component of sustainability efforts. With this information, we can more effectively and efficiently work with payers on securing reimbursement. And, effective reimbursement gives Wisconsin the best chance of sustaining SBIRT service delivery after our federal grant funds cease.

We know that regular submission of claims information will not be a trivial task, and we appreciate and thank our clinical sites for partnering with WIPHL in this effort. A big thank you to our clinical site partners for providing information in support of this important sustainability effort.

As 2011 begins, many of us in Wisconsin will be cheering on the football Badgers in their Rose Bowl effort, anticipating success…and those of us involved in SBIRT will also be supporting our WIPHL team in sustainability efforts, anticipating success in reimbursement.

Happy holidays! And On, Wisconsin!

Meet the New Health Educators

Josh Taylor, BS
Site Operations Team

Welcome Wave IX! We are please to have four promising new health educators (HEs) and two new clinics on board. Here is a brief introduction to our new HEs.

Lekesha Allen
Health Care for the Homeless

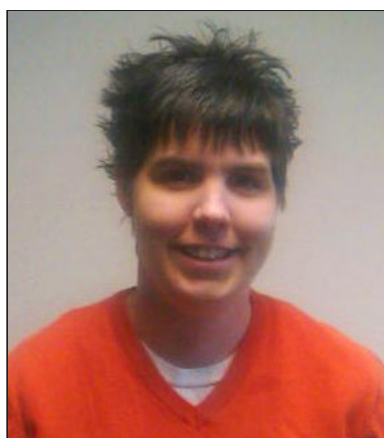
Lekesha holds a MS degree in social work from the University of Milwaukee and a BS degree in social work from Mount Mary College. Her most recent work experience has been with the Bureau of Milwaukee Child Welfare as an Advanced Initial Assessment social worker where she was conducting child protective service intakes and assessments of suspected child abuse/neglect.

Jen Promer
Columbia St. Mary's Family Health Center

Jen holds a BS degree in Life Sciences Communication from the University of Wisconsin -Madison. During college she worked at the UW School of Medicine and Public Health and also volunteered for Colleges against Cancer. Between volunteering and taking an internship with the Outagamie County Public Health Department Jen realized her passion for preventative health.

Kristine Davis
Baldwin Area Medical Center

Kristine holds a BS degree in Human Development and Family Studies from the University of Wisconsin-Stout. Her past work history, totaling more than 10 years of experience, has included being a guardian/conservator for Lutheran Social Services, and working for the Advocacy Center for Long-Term Care and also as a patient representative.



Beth Collier
Health Care for the Homeless

Beth holds a BS degree in Criminal Justice from Northern Michigan University. She will soon have an MS in Social Work from the University of Milwaukee. She previously worked for Wisconsin Correctional Services, St. Joseph Hospital, and for the Great Lakes Recovery Center. Beth will not only provide SBIRT services as an HE; she will also serve as the clinic champion for Lekesha's site.

Month end data

Year 5 Month 3

November 15 – December 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)	156	127	81.4%	36	28.3%	54	150.0%
Aurora Sinai Women's Health Center (0.9 FTE)	158	155	98.1%	33	21.3%	64	193.9%
Aurora Walker's Point (0.9 FTE)	213	213	100.0%	62	29.1%	56	90.3%
Beloit Area Community Health Center	209	205	98.1%	56	27.3%	50	89.3%
Columbia St. Mary's	53	53	100.0%	8	15.1%	7	87.5%
Family Health/ La Clinica (0.5 FTE)	92	92	100.0%	23	25.0%	6	26.1%
Gundersen Lutheran Family Med	341	338	99.1%	86	25.4%	46	53.5%
Gundersen Lutheran Trauma Center	96	N/A	N/A	N/A	N/A	92	95.8%
Health Care for the Homeless - Recovery Clinic	54	54	100.0%	29	53.7%	23	79.3%
Menominee Tribal Clinic	470	352	74.9%	63	17.9%	60	95.2%
Milwaukee Health Services, Inc. (0.3 FTE)	13	5	38.5%	5	100.0%	5	100.0%
Northeast Family Medicine	259	220	84.9%	81	36.8%	74	91.4%
Scenic Bluff's Community Health Center (0.2 FTE)	17	17	100.0%	2	11.8%	0	0.0%
Scenic Bluff's Community Health Center (0.2 FTE)	228	224	98.2%	62	27.7%	61	98.4%
Grand Totals	**2,359**	**2,055**	**87.1%**	**546**	**26.6%**	**598**	**109.5%**

*Eligibility varies by clinic

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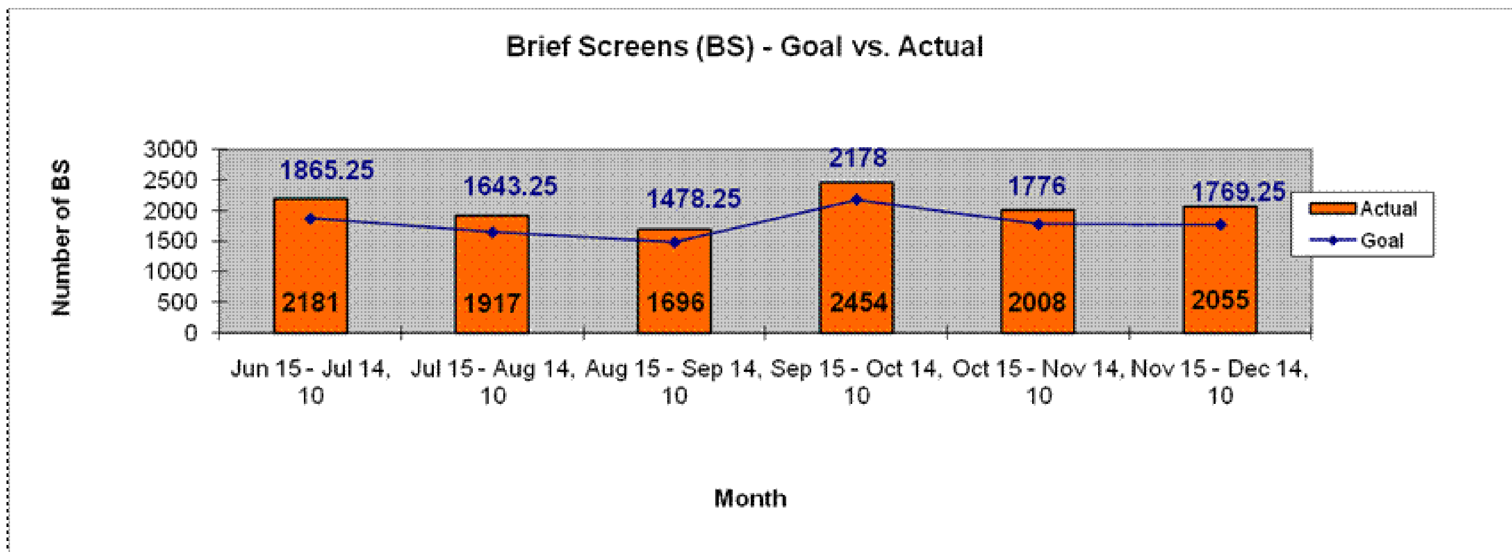
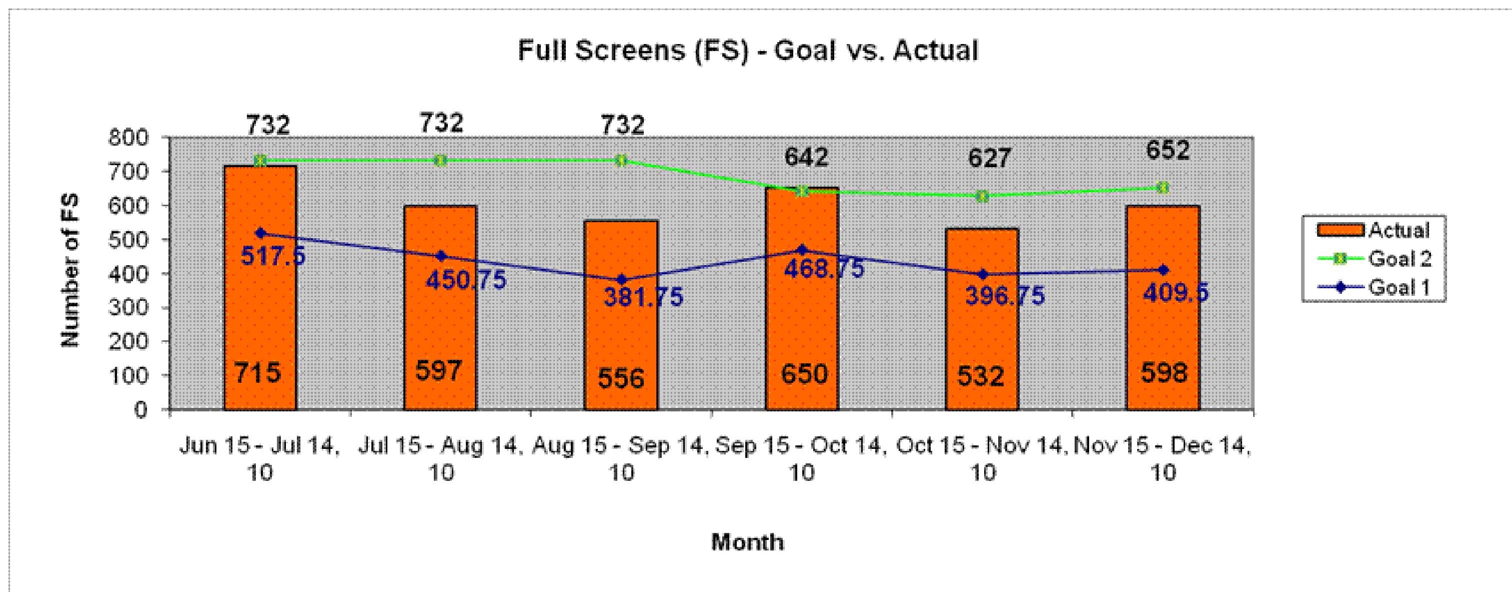
6 month wrap-up



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



Actual: Number of full screens completed
Goal 1: Year 5 (Sept 15, 2010 - May 14, 2011) - Full screen 75% of patients who brief screen positive
Goal 2: Year 5 (Sept 15, 2010 - May 14, 2011) - Number varies by site based on start date

Cultural Competence Update

Caregiver Stress, Mental Health, and Culture

Kevin Browne, Ph.D.
WIPHL Cultural Competence Consultant

Over the past several decades U.S. social policy has directed health care for chronically mentally ill, disabled, and dementia sufferers toward community and home-based care. At the same time, the population in the U.S. and many other nations is rapidly aging. The confluence of these two trends has resulted in a dramatic rise in the provision of informal health care for older ill and disabled family members by other family members, a growth that is likely to continue.

This informal care often creates significant emotional, physical, and lifestyle burdens on caregivers. Rates of anxiety and depression in this group are significantly higher compared to the general population. Caregivers are also more likely to use psychotropic drugs, be socially isolated, have sleep problems, and report a reduced quality of life. The majority of caregivers are women, most also hold jobs outside the home, and they often provide caregiving for several years. There is also evidence that among some groups caregivers tend to make more visits to physicians and use more prescription medications than non-caregivers.

The caregiving experience and help-seeking behavior are culturally-shaped. Latino caregivers, for example, are more likely to be younger, poorer, less educated, and have worse mental and physical health problems than whites. And the incidence of Alzheimer's disease and dementia among Latinos in the U.S. is rising rapidly, which will also result in many more caregivers. Stigma is a frequent barrier to caregivers seeking help. Among many cultural groups, dementia-related changes are often interpreted by family members as a normal part of aging, and seeking formal health care may be perceived as leading to excessive worry and avoided due to social stigma.

Caregiving is a pervasive and growing phenomenon in the U.S. Health care providers need to understand the burdens associated with caregiving, and inquire of patients whether caregiving for family members is part of their experience.

Selected References

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The Last Word

Changing directions
From a health educator in southeastern Wisconsin

A patient returned to his clinic for a follow-up session with a Health Educator. The patient and his Health Educator were working together to coordinate a referral to treatment for him. The patient and his partner are expecting a child together in the next few months and he wants to get healthy for himself, his partner, and their future child. He also shared that he also wants to use his experiences to better serve his community. One of his life goals is to be a mentor for others and he sees making changes in his own drug use as the first step in that new direction.

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