The WIPHL Word

Wisconsin Initiative to Promote Healthy Lifestyles

February 2009 www.wiphl.org Volume 3 No. 2

The Director's Desk

Toward Evidence-Based, Patient-Centered Alcohol and Drug Treatment

By Richard L. Brown, MD, MPH
Clinical Director

Has anyone noticed that out of more than 50,000 patients that WIPHL has screened, only 69 have entered treatment, while thousands have been found to be dependent on alcohol or drugs? What's going on?

Sadly, part of the answer comes in recent publications and talks by such leaders in the substance abuse treatment field as Bill Miller, PhD, and A. Thomas McLellan, PhD. Dr. Miller is a retired professor of psychology and director of the University of New Mexico's Center on Alcoholism, Substance Abuse, and Addictions. Dr. McLellan is a professor of psychology and CEO of the Treatment Research Institute at the University of Pennsylvania. Both agree that our substance abuse treatment sector in the U.S. is very broken.

One problem, of course, is the multitude of barriers that must be overcome for patients to enter treatment. Funding is a major barrier for many uninsured and insured patients, but even with complete insurance coverage or complete funding from WIPHL, child care, work schedules, and transportation can be barriers. The latter barrier is especially high in many rural areas. Cultural issues can be important, too. If a treatment program mainly serves white males, non-whites and females may not ever get comfortable enough to benefit.

But beyond those barriers, let's consider why our dependent patients decline treatment, and what their reasons say about the treatment that's available.

"I really think I can handle it on my own." Most patients do bring a lot of past successes and strengths to the table. Even if some treatment programs build on those strengths, that may not be evident to prospective clients, who often feel like cogs in a wheel rather than special individuals when they are told they must undergo what they view as cookie-cutter processes like intake, assessment, group, and meetings.

"I really don't feel comfortable talking to strangers in groups." In other medical realms, including mental health, patients' desires for privacy are respected. They may be offered participation in groups but are never required to accept group therapy.

*"Maybe I have a problem, but I don't need to go **there**."* "There" usually conveys the stigma that patients feel about people with alcohol and drug problems and people and programs that treat them.

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Medicaid May Cover SBIRT Services!

The state budget proposed by Gov. Jim Doyle extends Medicaid coverage for SBIRT—which up to now has been limited to pregnant women enrolled in BadgerCare Plus—to all Medicaid recipients beginning July 2010. The proposed budget requires legislative passage to become law. Legislative action is expected by July. Regulations pertaining to SBIRT reimbursement would be worked out between then and July 2010.

"This is a wonderful development for the many people of Wisconsin who will be able to benefit from these services," says WIPHL's Rich Brown. "We at WIPHL look forward to taking advantage of this opportunity to bring evidence-based, cost-saving SBIRT services to more clinical settings and more patients around Wisconsin."

Our sincere thanks to Gov. Doyle and Secretary Karen Timberlake, Dept. of Health Services, for putting this proposal forward. We will share more information as it becomes available over the coming months.

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Sadly, most people who are free to choose alcohol or drug treatment don't. The majority of treatment recipients are coerced, usually by our criminal justice system. This is not to say that treatment is ineffective. Treatment works well, even when people are coerced. This is not to say that treatment professionals and programs aren't doing their jobs. They have been performing near-miracles with the chronically poor level of funding they've had.

But what would we do if we could design treatment from scratch according to what patients (consumers!) want? What if dependent people could come to their usual clinics for alcohol and drug dependence, just as they do for most other health problems? The barrier of stigma would melt away. There would be no worry about who sees their car in the parking lot or who sees them getting off the bus.

What if patients could receive care from their regular provider and another team member they come to trust, a health educator? What if the patient could receive advice when they wanted it and, in collaboration with their health professionals, design their own treatment plan? What if patients could set up experiments and learn for themselves what level of treatment intensity and what kind of treatment would allow them to attain their goals? Patients could decide for themselves what services to take advantage of. They could start by getting their feet wet and eventually decide if they need more help than they originally thought.

Dr. McLellan often speaks of the Home Depot model. The Home Depot slogan is "You can do it. We can help." People often like to try first to do it themselves. If they can, great. If not, then they ask for more help. (Home Depot makes more money on contracting than on retail purchases.)

And what if dependent patients could receive the latest pharmacotherapy to substantially decrease their cravings for alcohol or opioids? Data on the effectiveness of medications for alcohol and opioid dependence are overwhelmingly positive. Sadly, few patients are receiving these medications and most providers remain uncomfortable prescribing them.

WIPHL has obtained permission from SAMHSA to apply its treatment funds to these medicines. We will soon be developing a protocol whereby patients who cannot afford these medications—namely, naltrexone, acamprosate, and buprenorphine—can receive them, as prescribed by their primary care providers, for free.

We'd like your help thinking about this protocol. Some questions to consider are: Should patients who receive these medications have to commit to receiving simultaneous specialty-based treatment? If not, should they agree to see their health educators regularly? Should rules hinge on patients' ease of access to specialty-based treatment? Should there be any circumstances that should prompt cessation of funding for these medicines? We've started to gather information from some national experts on this topic. Feel free to start conveying to us your thoughts on this now, and we'll be asking for more organized input in the near future.

By the way, toward our goal of attracting more patients into treatment, we've applied for a grant from the UW School of Medicine and Public Health's Wisconsin Partnership Program. If we're funded, we'll be able to interview patients who are found to be dependent but decline treatment. We'll be able to ask them to describe the kind of assistance they would be willing to receive. Using that information, we'll design and offer the kind of treatment patients say they want and study its effectiveness. We'll focus especially on rural areas because treatment resources are especially lacking there, but I believe that what we learn will be useful for patients across Wisconsin.

We're glad to be in partnership with so many of you across the state to improve alcohol and drug services for your patients and our fellow Wisconsin residents. We hope that our efforts toward expanding access to pharmacotherapy and offering patient-centered treatment will help you help your patients better than ever. Please keep letting us know how we can do the best we can—so that you can, too.

Save the Dates!

Our next semiannual statewide conference takes place from **Thursday, April 23, 11 a.m., to Friday, April 24, 2:30 p.m**. at the Cranberry Country Lodge in Tomah (cozy suites for all!). We will feature enlightening speakers and sessions on reducing stigma in treating substance misuse and the longterm sustainability of WIPHL.

Please note that our '08-'09 contract with clinics requires attendance by health educators, clinical/administrative coordinators, and QI coordinators from each clinic. WIPHL will pay for up to four people from each clinic team to attend.

Registration opens on our website by March 1. We look forward to seeing you in Tomah!

Co-Occurring Conditions in WIPHL Patients

The WIPHL Governor's Policy Subcommittee on Best Practices for SBIRT for Co-Occurring Mental Health Needs, Tobacco and Trauma meets quarterly to discuss WIPHL's capacity to address behavioral health issues that commonly occur with substance use disorders. Last month, based on the data collected to date, the committee reviewed and discussed the numbers contained in the following report.

By Laura A. Saunders
Manager of Health Education and Subcommittee Chair

Introduction
WIPHL's current SAMSHA funding covers screening, intervention and referral to treatment (SBIRT) services for patients who screen positive for substance use disorders (SUDs). Eventually, WIPHL aims to provide integrated screening and intervention for a number of unhealthy behaviors and mental health conditions that are responsible for 40% of deaths in the United States and most chronic disease and disability. The U.S. Preventive Services Task Force recommends SBIRT services for tobacco, alcohol, drugs, and depression.

Subjects
Subjects were patients at 21 primary care and public health clinics. The responses to the questions about health behaviors were collected via paper and pencil questionnaire. Of the 41,818 patients included in the sample, 59.8% were female, 60.7% were white and 11.9% were Hispanic. The largest proportion (47.3%) of patients were between 36 and 64 years of age.

Additional demographic detail combined with patients' responses to the alcohol and drug screen is shown in Table 1 (see next page).

The data was collected as part of the WIPHL service delivery program (University of Wisconsin Institutional Review Board Exempt #M-2007-1011).

Analysis
Data was collected from March 15, 2007 to September 29, 2008. Data from all tablet computers was uploaded to a central server and was stripped of identifying information. Frequency analysis was done using SPSS.

Results
Almost all WIPHL clinics screen for at least one behavioral health problem in addition to alcohol and drug use. Table 2 (page 5) illustrates the prevalence of these disorders and their co-occurrence with SUDs. For example, 11 WIPHL clinics screened a total of 8,294 patients for tobacco use. Of those screened, 17% were positive for both tobacco use and substance use disorders, 36.9% screened positive for tobacco use, and of those who screened positive for tobacco use, 53% screened positive for SUDs.

Discussion
The WIPHL health educator model and infrastructure can easily be used to address other unhealthy behaviors and mental health conditions. WIPHL has already made inroads into some of these areas. One WIPHL health educator is doing billable brief interventions for tobacco cessation and at least three WIPHL clinics are poised to begin the delivery of services to patients who are depressed. All WIPHL health educators were trained in trauma containment and referral at a January retreat.

Reimbursement is falling into place for tobacco, alcohol, and drug use. Two WIPHL clinics are currently billing for alcohol and drug use services while others are making preparations to bill. One WIPHL clinic is billing for tobacco cessation services.

Major healthcare payers in Minnesota are providing incentives to clinics who provide the kind of depression services that WIPHL is starting to provide in three clinics. Directors of Wisconsin health plans are learning about WIPHL SBIRT services and have been approached about reimbursement. Preliminary results indicate that a few of them will reimburse for SBIRT services.

Conclusion
Wisconsin's healthcare providers have a wonderful opportunity to systematically advance the health of their patients by providing integrated screening and intervention services for unhealthy behaviors and mental health conditions. WIPHL can help make this happen.

It is clear that WIPHL health educators should be trained and supported to perform interventions for other behavioral health problems when funding for such is available and feasibility can be worked out.

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Table 1

All Patients	**14732**	**35.2%**	**27086**	**64.8%**	**41, 818**
	+ Alcohol Screen	%	- Alcohol Screen	%	Total
Gender					
Male	6384	44.7%	7906	55.3%	14290
Female	7873	31.4%	17170	68.6%	25043
Missing	475	19.1%	2010	80.9%	2485
Race					
Black	1245	35.7%	2238	64.3%	3483
Asian	97	20.0%	389	80.0%	486
Hawaiian Pacific Islander	17	32.1%	36	67.9%	53
Alaskan Native	10	47.6%	11	52.4%	21
Native American	985	33.7%	1941	66.3%	2926
White	9285	36.6%	16115	63.4%	25400
Multiple Race	211	45.5%	253	54.5%	464
Missing	2882	32.1%	6103	67.9%	8985
Ethnicity - Hispanic					
Yes	1454	29.2%	3529	70.8%	4983
No	11211	36.5%	19506	63.5%	30717
Missing	2067	33.8%	4051	66.2%	6118
Age					
0-17	20	14.7%	116	85.3%	136
18-24	3109	48.5%	3298	51.5%	6407
23-35	3740	43.3%	4895	56.7%	8635
36-64	6354	33.3%	12727	66.7%	19081
65 +	1032	20.6%	3989	79.4%	5021
Missing	477	18.8%	2061	81.2%	2538

Note: The percent in each column is the % of the total number of subjects in each row for that characteristic.

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Table 2

Behavioral Issues	# of clinics who screened for this issue	Total number of patients screened for _____	Prevalence of positive screen for _____	Prevalence of positive screen for behavioral issue and alcohol/drugs	Prevalence of positive alcohol/drug screen among those who screened positive for behavioral conditions
Tobacco use	11	8,294	17.0%	36.9%	53.0%
Poor nutrition	10	20,665	27.7%	72.6%	38.1%
Too little Exercise	10	11,713	16.9%	50.6%	33.3%
Weight Problems	6	10,185	24.3%	67.8%	35.8%
Depression*	5	4,198	12.8%	32.9%	40%
Violence	4	456	6.7%	13.0%	51%

*PHQ2: Specificity 57%; Sensitivity: 96% for identifying a major depressive disorder. Thus the PHQ2 is a great instrument for finding everyone who MIGHT be depressed but it can also find people who really aren't suffering from major depression.

Sign Up Now for February 24 Talk on Prescription Drug Misuse

The *WIPHL Speaker Series* continues with a talk about a rising trend in the addiction field—misuse of prescription drugs. WIPHL clinical director Richard L. Brown, MD, MPH will discuss how medical and counseling professionals can best help these patients.

When: Tuesday, February 24, noon to 1 p.m.

Where: At your desk! (Free teleconference, with PowerPoint slides and other materials to be made available beforehand.)

How to register: Go to Wisline registration: http://www.uwex.edu/ics/wlreg/wlwelcome.cfm. If you do not already have an account, you will be guided through steps to create one. If you have any registration questions or problems, please contact Wisline at 608/262-0753 or e-mail wislineaudio@ics.uwex.edu. For any other questions, please e-mail info@wiphl.org.

Please sign up at your earliest convenience—waiting until the last minute can result in event cancellation or unnecessary charges to us.

Project Manager Update

First Impressions

By Candace Peterson

I've spent my first three months as project manager getting to know the SBIRT project and the people around the state who are involved in delivering SBIRT services. I'd like to tell you what has impressed me the most about the SBIRT initiative from my time here thus far.

1. During site visits and the recent health educator meeting in Madison, I have had a chance to meet most of our health educators and some clinic staff. The more I learn about the challenges, the successes, and the patient impact of providing SBIRT services in clinics around the state, the deeper is my appreciation for the complexity and importance of this undertaking. I increasingly admire and am deeply grateful for the important SBIRT services provided in Wisconsin.

2. I am very fortunate to be working on the SBIRT initiative with the people who are involved in this project. I cannot imagine finding individuals who are more competent, dedicated, passionate, and flexible than the staff at the Coordinating Center, our colleagues at the Wisconsin Division of Mental Health & Substance Abuse Services (our contractor), the grant and budget administrators at the University of Wisconsin Medical Foundation, and the University of Wisconsin Population Health Institute staff (the people leading the SBIRT evaluation effort).

Thank you to all of the SBIRT and WIPHL people I have met; each one of you has been incredibly kind and helpful as I learn to navigate the SBIRT project waters. I look forward to getting to know you better and to working more closely with you in 2009.

I am excited and proud to play a role in shepherding WIPHL's efforts in the SBIRT initiative, and will devote considerable attention to the sustainability of SBIRT services in Wisconsin.

Treatment Liaison Update

Treatment: Numbers and Meaning

By Mia Croyle

One aspect of the treatment liaison job is the coordination of the SBIRT treatment funds. These funds are a part of our grant and are intended to be used to reduce barriers to treatment for those patients who, after meeting with the health educator, have the motivation to enter specialty addiction treatment services but do not have the funding resources to afford that treatment. These funds are a safety net of sorts for the patients with whom we work.

These funds are administered by DHS and disbursed through the counties and tribes where our clinics are located. In the second year of our grant (September 15, 2007–September 14, 2008), $86,073.50 was spent to fund treatment for 37 patients. Of those 37 patients, 21 patients received treatment in a residential setting and 16 patients received treatment in an outpatient setting.

It may seem unusual that the majority of the patients who utilized SBIRT funds to finance treatment received residential care—but it is important to note that this level of care is rarely covered by private insurance, is not covered by Medicaid, and that counties often have long waiting lists for county funding for this level of care.

Because WIPHL only funds treatment as a payer of last resort, we can safely say that patients whose treatment services were funded by SBIRT treatment funds would not otherwise have received treatment, at least not at this level of quality. Indeed, while the number of patients who have been referred to specialty addiction treatment through WIPHL remains relatively small compared to the number of patients who receive other WIPHL services, for those patients in treatment WIPHL may well have saved their lives.

In January, we had:
14 new referrals to treatment (current project total: 207)
2 patients enter treatment (current project total: 69)

Cultural Competence Update

Good Reads for Cultural Competence

By Harold Gates

A couple of newsletters that have come across my desk recently are from the University of Wisconsin-Madison, Institute for Research on Poverty (Focus 26:1, Summer-Fall 2008) and Portland State University, Research and Training Center (Focal Point, Winter 2000—Stigmatization). Both publications offer information and ideas relevant to our practice of cultural competence here at WIPHL.

Two articles from the Institute for Research on Poverty offer more insight into poverty: "A Primer on U.S. Welfare Reform" and "Rethinking the Safety Net: Gaps and Instabilities in Help for the Working Poor."

The first article gives us information on how we have transitioned from "Aid to Families with Dependant Children" (AFDC) prior to 1996 to "Temporary Assistance for Needy Families" (TANF). Like AFDC before it, TANF gives cash support to low-income families with children that usually are headed by a single mother. This program is the sixth largest in terms of spending (but comprises only half as much as is spent on subsidized housing, for example). This article and its conclusions can be found at http://irp.wisc.edu/publications/focus/pdfs/foc261c.pdf.

Discussions of the "safety net" usually focus on government programs designed to reduce poverty. Less frequently they address social service programs that help people get and keep jobs and improve their personal well-being. The author presents evidence of holes in the safety net. The locations of government and nongovernment agencies offering assistance do not match up well with the areas of greatest need. The conclusions and recommendations can be found at http://www.irp.wisc.edu/publications/focus/pdfs/foc261.pdf.

In general this newsletter provides a wealth of information and listservs to keep us informed on the latest developments in poverty research and can assist us in our work with all of our patients. I would encourage you to check it out!

"That's crazy." "He's insane." "You're out of your mind." These phrases are commonplace and demonstrate the pervasiveness of stigmatization of people with mental health conditions. But stigmatization is not just name-calling—it's also exclusion and discrimination. This issue of Focal Point is intended to support the goal of destigmatizing by providing state-of-the-art information about the causes and consequences of stigmatization along with strategies and programs to alleviate it. There are a number of very timely articles that inform the work of WIPHL and our Governor's Policy Subcommittees. Topics include the use of terminology, youth depression and its resulting stigma, and the experiences of LGBT youth. This edition of the newsletter and past copies can be viewed and downloaded for free on the Portland State University Research and Training Center website, www.rtc.pdx.edu.

Upcoming Learning Opportunity

The Wisconsin Association of Family and Children's Agencies presents:

Awareness and Mindfulness as a Pathway to Cultural Competence
with Don Coleman, LCSW
Midwest Center for Cultural Competence
Tuesday, May 19, 9 a.m. to 4 p.m.
Hilton Garden Inn, Oshkosh

Registration information can be found at www.wafca.org or e-mail sgust@wafca.org.

If you have further questions or need technical assistance, please e-mail me at Harold.Gates@fammed.wisc.edu or call (608) 265-4032.

Month End Data

January 15, 2009–February 14, 2009

Clinics	Eligible for BS*	Completed BS	% BS Completed	Positive BS	% Positive BS	Completed FS	% FS Completed
Wave 1							
Northeast	239	188	79%	90	48%	57	63%
Polk County	54	54	100%	16	30%	10	63%
St. Joseph's	331	324	98%	83	26%	74	89%
Totals	*624*	*566*	*91%*	*189*	*33%*	*141*	*75%*
Wave 2							
Amery	221	212	96%	76	36%	41	54%
FamHlt/LaCl. (0.5 FTE)	195	195	100%	58	30%	46	79%
Menominee	177	126	71%	42	33%	50	119%
Totals	*593*	*533*	*90%*	*176*	*33%*	*137*	*78%*
Wave 3							
Mercy Clinic South	157	114	73%	35	31%	17	49%
Totals	*157*	*114*	*73%*	*35*	*31%*	*17*	*49%*
Wave 4							
Minocqua	219	200	91%	36	18%	22	61%
Totals	*219*	*200*	*91%*	*36*	*18%*	*22*	*61%*
Wave 5							
Family Care Center	103	95	92%	38	40%	39	103%
Mayfair (0.5 FTE)	201	195	97%	42	22%	11	26%
Milwaukee Health Services (0.3 FTE)	33	25	76%	8	32%	3	38%
Scenic Bluffs (0.2 FTE)	15	15	100%	2	13%	1	50%
St Croix Tribal Clinic (0.5 FTE)	39	17	44%	7	50%	6	86%
Totals	*391*	*347*	*89%*	*97*	*28%*	*60*	*62%*
Grand Totals	**1,984**	**1,760**	***89%***	**533**	***30%***	**377**	***71%***

*Eligibility varies by clinic
Data in this and accompanying charts compiled by Jessica Wipperfurth

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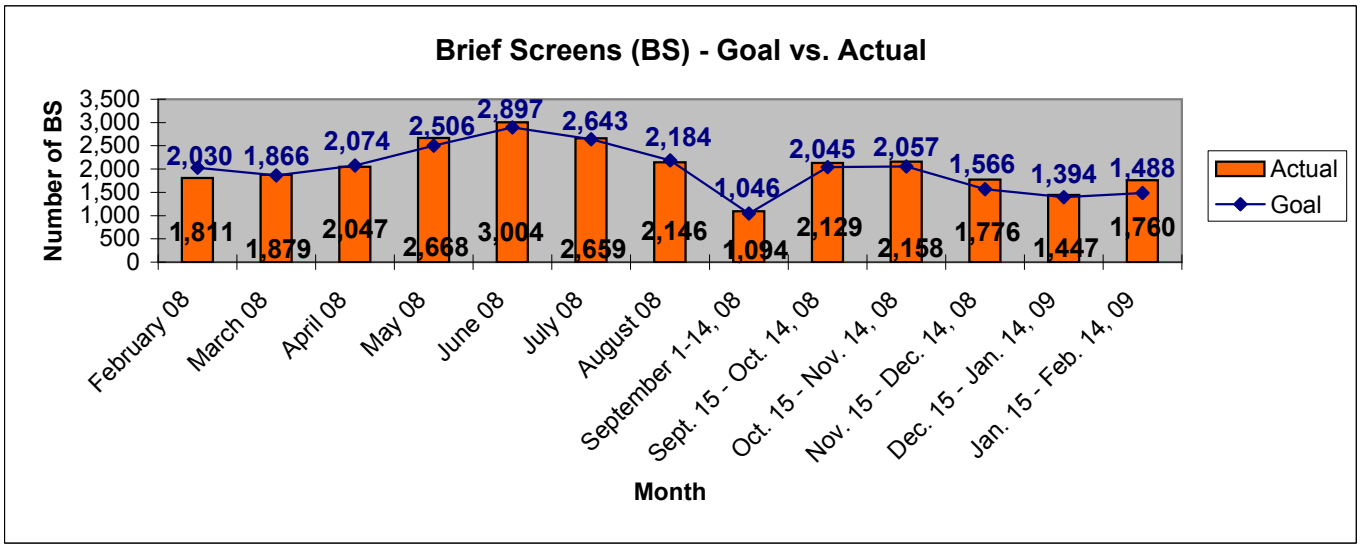
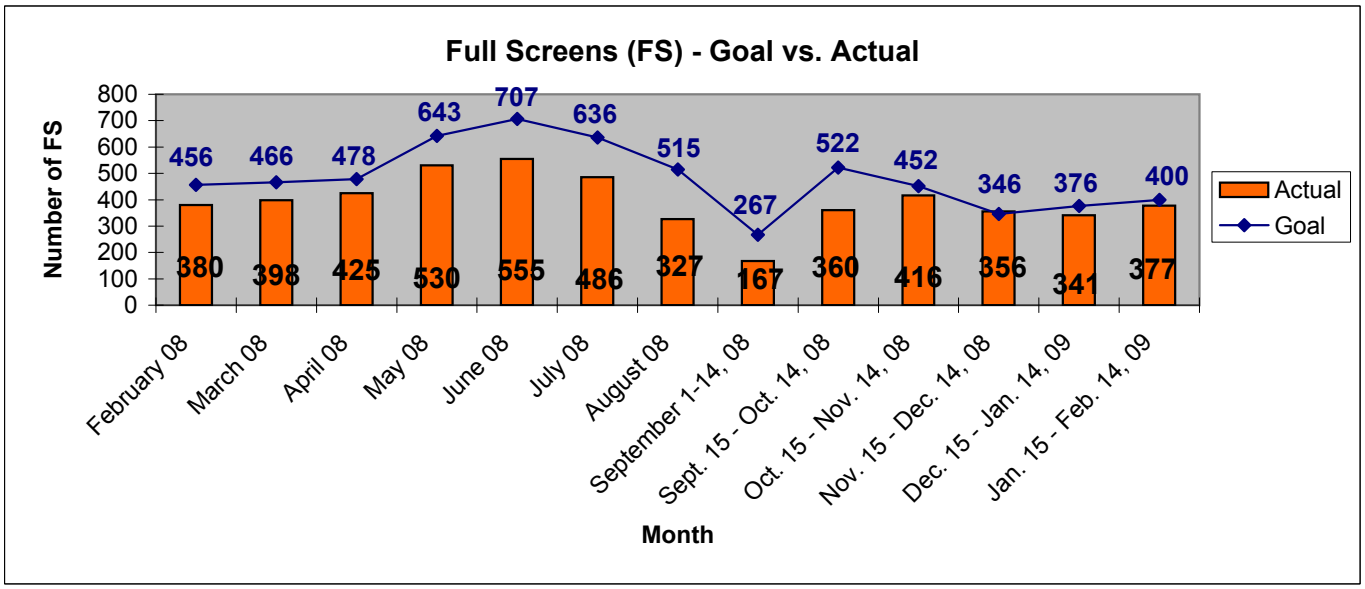
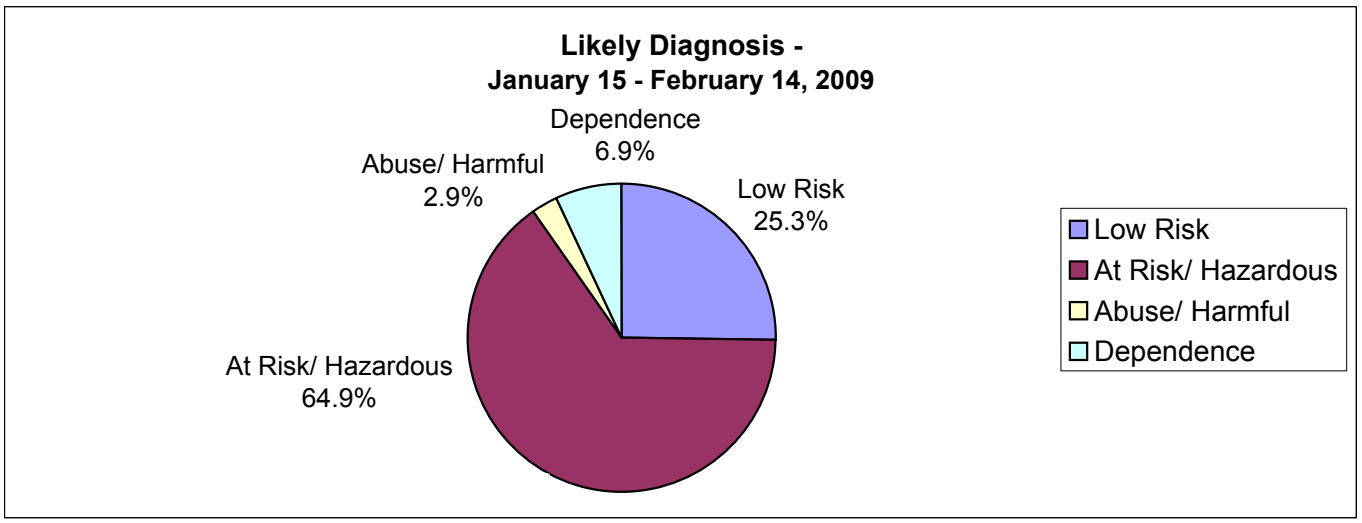
Year-to-Date Data



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



Actual: Number of full screens completed
Goal: Year 3 (Sept. 15, 2008 - Sept. 14, 2009) - P4P Clinics: Full screen 75% of patients who brief screen positive
Goal: Year 3 Quarter 2 Goal (Dec. 15 - Mar. 14, 2009) - WIPHL Funded: Full Screen 120 patients per clinic (prorated based upon % FTE)



Calendar

Feb. 24
WIPHL Speaker Series: Dr. Richard L. Brown on prescription drug misuse, free teleconference 12-1 p.m.
(See page 5 for registration info)

Feb. 25
HE Cultural Competence call featuring Gary Hollander on issues concerning LBGTQA patients, 12-1 p.m.

March 3–14
Wave VI Health Educator Training

March 5
Governor's Policy subcommittee, Access for Adolescents, 11 a.m.–1 p.m.

For other Health Educator calls and additional information about events, see www.wiphl.org

The Last Word

"Making up your mind in your heart"

The presence of health educators at WIPHL's partnering clinics can encourage people to feel safe talking about their substance abuse problems even if they are not WIPHL patients. Here's what a health educator recently experienced at a clinic in northern Wisconsin:

I went out to our main lobby area to get some hot water for tea, and I smiled at a gentleman who was standing next to the coffee machine and he just said to me, "Yesterday I celebrated 10 years of sobriety from alcohol!" I used a little MI on him and said "You must be very proud of yourself, you sound like that is very important to you!" He starting talking to me right there and told me how he's now trying to get into working with schools to tell kids his story and that if he can just reach one person, then it's all been worth it.

Then he said, "I don't want to tell them what they have to do, but I want them to know that if they need to make a change, then they CAN do it. If they make up their minds in their hearts, then they are capable of making good changes." We talked for a few more minutes. I was just so struck by this because I'd never met this person before. He just decided to tell this to me.

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's Department of Family Medicine. Readers are encouraged to send suggestions and submissions to editor Joan Fischer at Joan.Fischer@fammed.wisc.edu.