The WIPHL Word

Wisconsin Initiative to Promote Healthy Lifestyles

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The Director's Desk

Yet More Support for SBIRT in Healthcare Settings

By Richard Brown, MD, MPH,
WIPHL Project Director

It seems like not a week goes by without another important individual or organization throwing its support behind the systematic delivery of evidence-based, cost-saving behavioral screening and intervention services in healthcare settings. Most recently, US Surgeon General Regina M. Benjamin, MD, MBA joined the charge with the release of her draft national prevention strategy (http://www.healthcare.gov/center/councils/nphpphc/draft_recommendations.pdf).

Of course, the position of Surgeon General carries quite a bit of credibility. But even before she became Surgeon General, Dr. Benjamin was already quite a medical heavyweight, with high-level positions at the American Medical Association, the Federation of State Medical Boards, the National Academy of Sciences, and more. You can read about her at http://www.surgeongeneral.gov/about/biographies/biosg.html.

The Surgeon General's strategy aims to reduce preventable death, disease and injury in the US. Goals include expanding the delivery of clinical prevention services and empowering and educating individuals to make healthy choices. The plan specifically mentions tobacco, alcohol, drug and mental health screening and intervention services, including "SBIRT."

This report comes several weeks after Secretary of Health and Human Services Kathleen Sebelius released a five-year strategic planning document that calls for delivery of evidence-based prevention services regardless of patients' payers and providers. Key federal officials are clearly singing the same tune.

Surgeon General Regina M. Benjamin, MD, MBA

Soon, be on the lookout for Secretary Sebelius' more detailed plan to improve the quality of US healthcare. I'd bet dollars to doughnuts that we'll start to see more detailed expectations on how this will all happen.

Of course, because of our efforts in Wisconsin, we'll have a huge head start toward meeting any new requirements. So thanks to the many administrators, providers, staff and, of course, Health Educators, who are on the frontlines delivering behavioral screening and intervention services in healthcare settings across our state. Because of your efforts, Wisconsin will be poised to move quickly, meet new requirements, and expand services that help many patients, strengthen families and communities and improve the bottom line for Wisconsin businesses.

Project Manager Update

Adults Over 50 Struggle with Alcohol and Drug Abuse

By Candace Peterson, Ph.D.,
WIPHL Project Manager

There are 77 million baby boomers in the US, and we now have perhaps the first sizeable population of over-50 adults struggling with not just alcohol but with drugs as well. The Substance Abuse and Mental Health Services Administration (SAMHSA), a federal agency, forecasts that as this population ages, the number of baby boomers with substance abuse disorders will double from 2.5 million (1999) to 5 million (2020). This means that the need for effective screening, brief intervention and treatment for this population will also increase dramatically.

Nationally (and in Wisconsin), alcohol remains the most commonly abused substance among the upper age brackets, though use of marijuana, cocaine, and heroin are rising in this age group. Prescription drugs can add to the problem. Over the past two decades opium-based and synthetic opioid painkillers are some of the most widely prescribed drugs in the U.S.

But the human body, as it ages, has a declining ability to metabolize alcohol and drugs, so older adults who abuse substances are sensitive to smaller amounts than when at a younger age… yet often don't realize this, which can lead to problems at lower levels of use.

Preventing harm from substance abuse in the over-50 population in Wisconsin is an important and necessary public health strategy, and delivering SBIRT services to all adults in various clinical care settings is one important way to do so.

Access to SBIRT Update

Motivational Interviewing: Not just for WIPHL Health Educators

By Mia Croyle, MA, &
Laura Saunders, MSSW,
WIPHL Site Operations

The WIPHL Health Educators are part of a growing body of practitioners who use and get coaching and support in the use of Motivational interviewing (MI). We were busy in 2010 training our Health Educators in MI. There has also been interest in MI from many fields and disciplines outside substance abuse and healthcare. It seems there is something about MI that resonates with people in many fields doing many kinds of work.

There is a growing body of research that supports the effectiveness of MI for a variety of other behaviors as well. The chart below illustrates this.

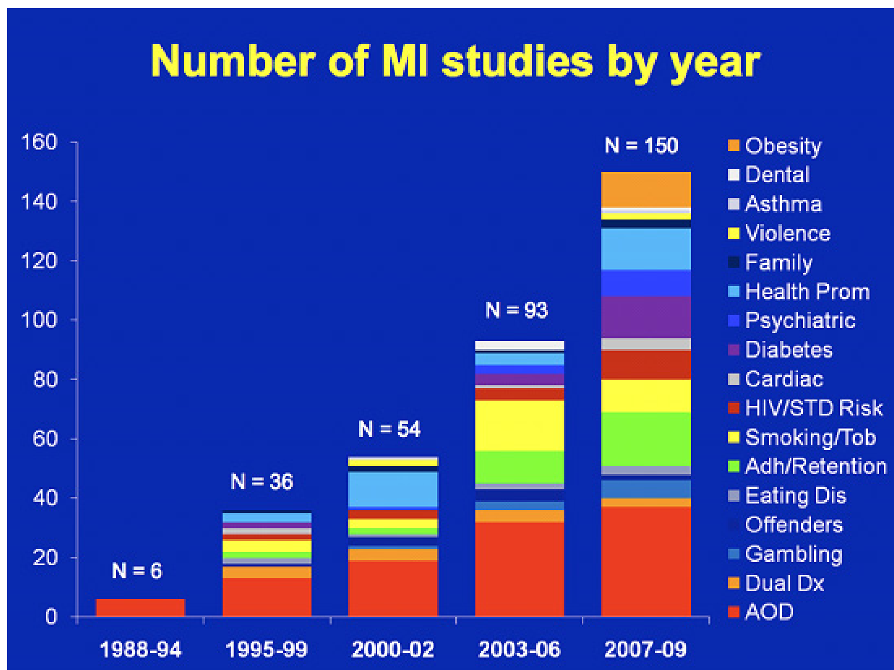

Chart courtesy of Scott Caldwell, MA, CASC

In the last year alone, WIPHL staff have provided training to staff who work in agencies doing home health and child abuse prevention, correctional staff in 3 states, a managed care group who provide services to keep persons with disabilities in their homes, and agencies who offer training and support to child care providers, and organizations who work with persons experiencing homelessness. We've even been asked to train MI to other staff at some of our partner sites, including clinic managers, medical assistants, nurses, and clinic support staff. Others in Wisconsin are out there training MI for use in schools, HIV programs, organizational change, restorative justice, trauma work, and supervision.

The full implementation of an effective MI practice takes more than a single workshop. Personalized feedback can bridge the gap between what is learned in a workshop and actual practice. A growing number of agencies are recognizing this and are making a commitment to MI and are establishing processes by which individualized feedback and coaching is provided for their practitioners. This is the kind of ongoing monitoring and supervision that WIPHL Health Educators have been getting since the beginning of our program. Our program, our partner sites, Health Educators, and patients all continue to reap the rewards of this commitment to quality.

Month end data

Year 5 Month 4

December 15, 2010 – January 14, 2011

Clinics	Eligible for BS*	Completed BS	% BS Completed	Positive BS	% BS Positive	Completed FS	% FS Completed
Aurora Sinai Family Care Center (0.9 FTE)	71	53	74.6%	18	34.0%	24	133.3%
Aurora Sinai Women's Health Center (0.9 FTE)	141	128	90.8%	24	18.8%	43	179.2%
Aurora Walker's Point (0.9 FTE)	207	208	100.5%	56	26.9%	60	107.1%
Baldwin Area Medical Center	1220	321	26.3%	98	30.5%	8	8.2%
Beloit Area Community Health Center	178	175	98.3%	37	21.1%	35	94.6%
Columbia St. Mary's	414	389	94.0%	90	23.1%	66	73.3%
Family Health/ La Clinica (0.5 FTE)	113	113	100.0%	25	22.1%	12	48.0%
Gundersen Lutheran Family Med	286	261	91.3%	67	25.7%	37	55.2%
Gundersen Lutheran Trauma Center - Adolescent	2	2	100.0%	0	0.0%	0	0.0%
Gundersen Lutheran Trauma Center - Adult	94	N/A	N/A	N/A	N/A	91	96.8%
Health Care for the Homeless	198	198	100.0%	90	45.5%	97	107.8%
Menominee Tribal Clinic	348	274	78.7%	51	18.6%	50	98.0%
Milwaukee Health Services, Inc. (0.3 FTE)	20	2	10.0%	2	100.0%	2	100.0%
Northeast Family Medicine	215	177	82.3%	59	33.3%	54	91.5%
Scenic Bluff's Community Health Center (0.2 FTE)	10	10	100.0%	5	50.0%	2	40.0%
Waukesha Family Practice Center	237	223	94.1%	67	30.0%	62	92.5%
Grand Totals	**3,754**	**2,534**	**67.5%**	**689**	**27.2%**	**643**	**93.3%**

*Eligibility varies by clinic

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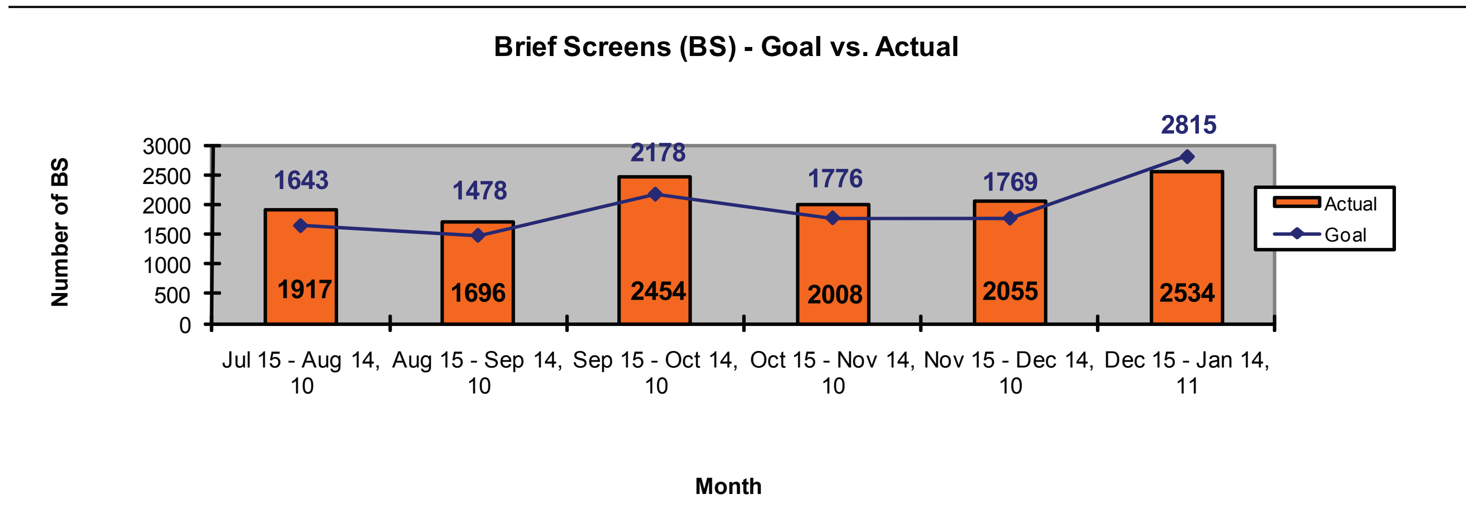
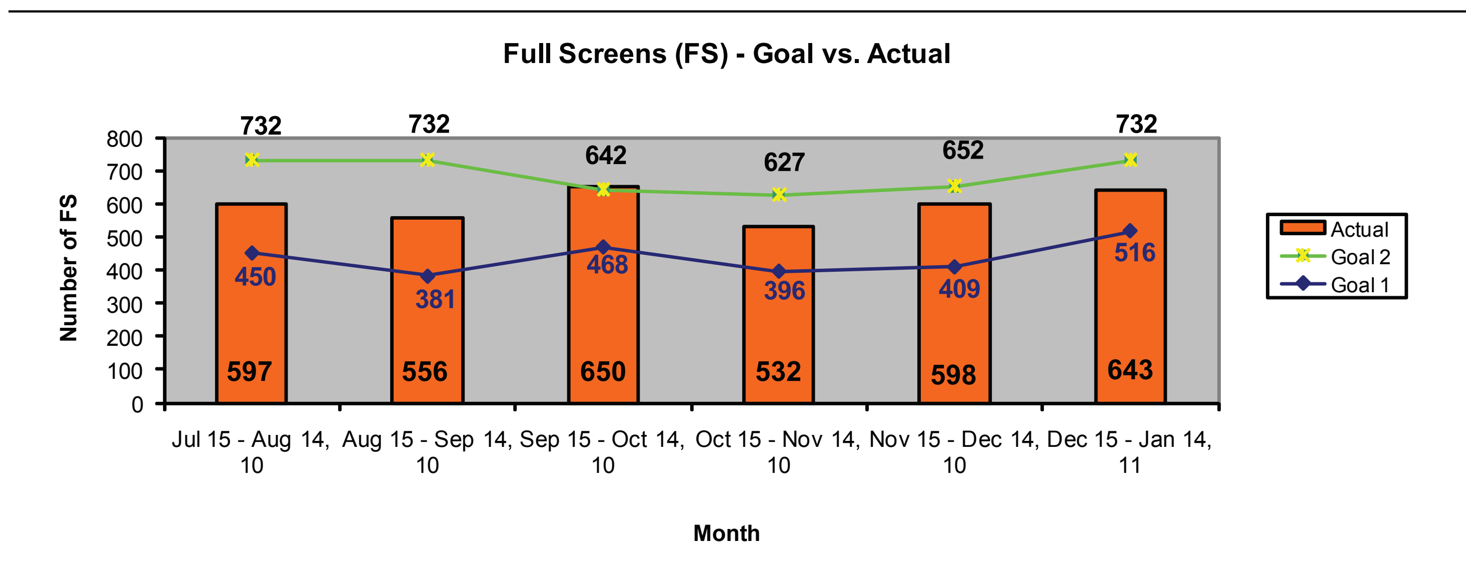
6 month wrap-up



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

Culture, Stigma, and Substance Abuse

By Kevin Browne, Ph.D.,
WIPHL Consultant on Cultural Competence

Stigma is the experience of feeling defective in comparison to others due to a perceived attribute or characteristic. The result of stigma is that the person feels shunned, ashamed, and isolated from meaningful social relationships. Stigma is often internalized, causing a double victimization for the person suffering illness or disease. Moreover, because many mental health and medical conditions involve the perception that there is some aspect of personal culpability due to lifestyle choices or dangerousness, stigma can also implicate the person's family and community.

Health care ideology and practice is inevitably pervaded by cultural values and beliefs. These beliefs influence, often sub-consciously, how we interpret the values and practices of the patients we encounter. Sometimes these beliefs cause health professionals to stigmatize patients who engage in behaviors that contradict their cultural values. In the case of substance abuse, it may seem natural to many health professionals that people should try to help themselves, to try to recover from substance abuse. Not appearing to do so can trigger stigmatizing attitudes toward patients. In a study of stigmatized attitudes among health professionals, for example, Rao et al (2009) found that patients with active substance abuse disorders were highly stigmatized compared to patients whose substance abuse disorder was in remission.

In the process of becoming more culturally competent, we need to be aware of our cultural values in relation to the patients we work with. We need to be mindful of when these judgments get triggered and how they may influence the way we see a patient. We also need to inquire about how our patients see their substance use and the idea of self-help, and engage in culturally competent ways of supporting change.

Reference:

Rao, H., H. Mahadevappa, P. Pillay, M. Sessay, A. Abraham, J. Luty, 2009. A study of stigmatized attitudes towards people with mental health problems among health professionals. *Journal of Psychiatric & Mental Health Nursing* 16 (3): 279-284.

The Last Word

Quit? No WAY! Cut back? SURE.

From a Health Educator in southern Wisconsin

A Health Educator (HE) was asked by the attending physician to speak with a patient about smoking. According to the physician, the patient wanted to quit. The HE and the patient instantly recognized one another—the HE had previously talked with this patient about his alcohol use. It would seem that his previous relationship with the HE allowed him to feel comfortable telling the truth which was--- I don't want to quit smoking. I don't know why the doc sent you in here. The HE started by reminding him that the decision to quit, or not, was entirely up to him and asked him a series of open questions about his use and it's impact on his life. By the end of their conversation the patient was going to try and cut down his smoking by a ½ pack a day!

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