The WIPHL Word

Wisconsin Initiative to Promote Healthy Lifestyles

January 2008 Volume 2 No. 1

The Director's Desk

A New Year: Looking Back and Looking Forward at Quality

By Richard Brown, MD, MPH
Clinical Director

As we look back over 2007—wow, what a busy and exciting year WIPHL had. Our first few WIPHL clinics started delivering a trickle of services in late March. As of December 31, we had 20 active WIPHL clinics, and a total of 31,339 patients had received brief screening services. We've been very successful. Thanks to everyone who has helped this happen—from those of you on the front lines who interact directly with patients to those of you behind the scenes at each clinic, in Madison, and in Washington.

New Years is also a time to look ahead, and many of us undoubtedly have set some resolutions for ourselves. As we at WIPHL look ahead to the rest of 2008, we ask you to join with us in renewing our commitment to the quality of the services we deliver to patients across Wisconsin.

Over the next several weeks, we will be re-emphasizing quality in three major ways:

1. Central Office—We will be bolstering our own quality improvement (QI) efforts in the central office, which have lagged because of staff shortages. Holly Prince, who developed expertise in QI in her previous position with the Network for the Improvement of Addiction Treatment (NIATx), has been busy providing treatment liaison services and modifying our computer tablet system. Now that Mia Croyle is working in our central office and providing excellent treatment liaison services, Holly will soon have more time to focus on QI. An initial aim will be to shorten the time to get dependent patients started in treatment. Holly will be implementing plan-do-study-act (PDSA) cycles just as we've asked all of our participating clinics to do. We welcome suggestions on other possible focuses for QI work at the central office.

2. Full Screening, Intervention, and Referral Services–A key determinant of the effectiveness of any clinical service is the rapport between patient and provider. This is especially true when the therapeutic instruments are the providers–our health educators!–rather than medications or surgical procedures. The research literature leaves no doubt that the alliance between patient and provider is the most important predictor of effectiveness in the realm of behavioral services. Experts at a recent national meeting of SBIRT program evaluators confirmed that the best and most frequently used measure of alliance is the Working Alliance Inventory, which has already been shortened from its initial 36 questions to 12 questions. We've gotten very helpful feedback from health educators and others at our partnering clinics that a list of 12 questions remains too long for busy primary settings, so we are working with psychology researchers here at UW-Madison to determine the fewest number of questions that will still give us useful information. Such information will help us document the quality of care we are providing, recognize where there might be need for improvement (such as refining our protocols to better serve patients in certain age, gender, racial, and ethnic groups), and identify best practices. We hope to be in touch with everyone at our clinics later this month about a possible super-brief alliance measure.

3. Brief Screening and Hand-Offs to Health Educators–I recently attended a meeting in Chicago where initial national conversations took place on developing measures of quality of services for alcohol and drug issues. The convening of this group by the American Medical Association signifies that all healthcare settings, including primary care settings, will soon be held responsible for providing SBIRT services–and graded on how well they do it. It will be a formidable task to develop measures that are equally applicable to all settings where services are provided, such as treatment centers, hospitals, emergency departments, and primary care clinics. clinics. Interestingly, the conversation has focused so far on exactly the kinds of measures that we are using at WIPHL:

Director's Desk continued

• The proportion of eligible patients who get brief screening.

• The proportion of patients with positive brief screens who receive additional services.

• The proportions of patients with various levels of risk (as determined by a full screen of the kind our health educators deliver) who receive appropriate services, such as brief intervention, referral to conventional treatment, brief treatment, or offers of medications for alcohol or opioid dependence.

Some people object to what seems to be a cold and literally calculating approach to quality improvement that seems to treat patients more like numbers than people. We, like the experts who recently met in Chicago, certainly see patients as people–people whose lives will be longer, healthier, and happier, and people whose families and communities will be healthier and safer, if our health educators can provide SBIRT services to the largest possible numbers of patients.

We know that adding such preventive services to already very busy clinic agendas is difficult. While some of our clinics are in the groove in one or more ways–delivering brief screens to the most patients, having the most patients with positive brief screens see their WIPHL health educator, and providing a volume of services that can sustain health educator compensation when reimbursement begins–it's natural and expected for other clinics to struggle with this.

For those who continue to struggle, it's good news that the route to success already has been well mapped. According to the Institute for Healthcare Improvement and lots of research literature, rigorous implementation of plan-do-study-act (PDSA) cycles is the well-worn path to optimizing health services.

So, as 2008 begins, I hope you will join us in a resolution to continue optimizing the quality (which includes quantity) of SBIRT services we're all delivering. Once things are running smoothly, simply monitoring measures may be all that's necessary to make sure there's no slippage. And when improvement is needed, just a few rigorous PDSA cycles may be all it takes before discovering how to make WIPHL work best to promote health, safety, and happiness among your patients, families, and communities.

Speaking of health, safety, and happiness–I wish that for all of you and your loved ones throughout 2008.

Health Educator Update

HE Resolutions

By Laura A. Saunders

As many of our patients set out to make New Year's resolutions, they may be more receptive to advice provided by WIPHL health educators. Some patients may even remember previous encounters with their HEs and seek them out because they feel ready for change.

In keeping with that theme, our HEs have their own work-related resolutions. They include:

• Getting all providers on board with that clinic's current method of screening ALL patients for one provider face-to-face each day.

• Tracking patients who have completed the brief screen better so that patients who have NOT completed the screen can't say, "Oh, I've already done that."

• Using lots of deep reflections when talking with patients. As one HE noted, "They really seem to get the patients going!"

• Getting additional training and professional certification

• Increasing the number of face-to-face contacts; doing more full screens in person

• Figuring out systems to catch missed people at their next visit

None of these goals can be reached by the health educators alone. They all will require effort and buy-in from the WIPHL implementation team at each site. Choosing one of these goals might be a perfect place to start your clinic's 2008 PDSA cycles.

2007 was indeed a year of a lot of change for me and for all of the health educators. Everyone started a new job, learned or relearned motivational interviewing, and helped pioneer a new way to deliver SBIRT services in primary care and human service locations. While there is a lot of pioneering yet to be done in 2008, surely the year also will bring a lot of success.

Cultural Competence Update

The Latest on CC

By Harold Gates

As 2007 comes to a close, it has been a busy and productive year. We had our monthly Cultural Competency Committee meeting on December 14. The meeting was well attended (19 people from the various clinics around the state) and there was a lot of ground covered. After the welcome and introductions, we had a lively round robin discussion on the topic, "Understanding the Culture of Poverty." Staff from Aurora Family Care Center shared their experiences with patients and their ability to address patient needs in the ER as well as the logistical problems associated with time orientation, healthy diets, and other barriers to following up on appointments.

Staff from the Menominee Tribal Clinic shared their experiences with in-home care and the opportunity it presents for brief screening of elderly and home-bound patients. This service approach seems to work well in that setting. A number of staff and tribal members have been able to take part in the "Building Bridges Out of Poverty" training pioneered by Ruby Bridges, which has been useful in addressing a number of health-related issues the tribe faces on a day-to-day basis. Laura Saunders shared some concerns about WIPHL protocol that could be problematic when viewed from a poverty perspective. For example, ideas around "savings" relative to cutting back on AODA use and the impact that "relationships" have on patient self efficacy should be looked at carefully depending on the patient's socioeconomic standing. Laura and Mia Croyle discussed the usefulness of a document they received about helping patients living in poverty quit tobacco use and its applicability to the WIPHL brief screening, intervention, and referral to treatment model.

Finally, Christina Lightbourn, our health educator at UW Northeast, shared her experience with a patient from the Sudan and what she discovered from this particular cultural encounter. Her experience helped us to continue to be aware of the changing demographics of our patients and the need to continually upgrade our cultural knowledge and skills regarding the populations that we serve in our clinic areas. The remainder of our meeting focused on our progress on Act 292, protocol updates, including our protocol in Spanish, and the Governor's Policy Steering Committee/Subcommittees formation.

I was able to present an overview of cultural competency to the State Council on Alcohol and Other Drug Abuse (SCAODA) on December 7. The purpose of the presentation, which included a question-and-answer session, was to assist those present to better understand the work that the SCAODA Diversity Committee had done and the need to adopt the Culturally and Linguistically Appropriate Standards (CLAS) as a full council. These standards that were developed by the U.S. Department of Health and Human Services in 2000 would inform and guide the council's work in to the future once adopted. The adoption of the CLAS Standards, which had been approved by the Diversity Committee, was tabled until the March SCAODA Council meeting. The SCAODA Council, after a period of discussion, also decided to table until March the recommendation by the SCAODA Intervention and Treatment Committee (ITC). This committee had previously endorsed a recommendation to amend Act 292,so that WIPHL health educators could move ahead with service to this underserved population without having to "report" them. We will continue to build alliances around this issue and update you on our progress.

The SCAODA Diversity Committee met in the afternoon following the full council meeting. There were number of items requiring discussion, foremost among them being the need to recruit more members for this vital committee. Michael Waupoose, Diversity Committee chair, directed inquiries and recommendations for this committee to Gail Nahwahquaw at (608) 261-8883 or e-mail nahwagm@dhfs.state.wi.us. She staffs the committee for the Department of Health and Family Services. The SCAODA Diversity Committee also had a presentation regarding the Wisconsin Association for Alcohol and Other Drug Abuse's (WAAODA) Minority Training Institute. Angela McAllister directs this program and became a member of the Diversity Committee so that she could continue to connect the entities. The work of the subcommittees on the ADA and Cultural Competency was updated and continued to the January 3 committee

Cultural Competence continued

meeting. I will be on the agenda to report to them WIPHL's progress to date.

In other news, the Governor's Policy Steering Committee met on December 5 to solidify and discuss the subcommittee structure that will allow us to move forward on policy issues relating to the sustainability of WIPHL after SAMHSA funding ends. The four subcommittees are:

Promoting Demand for WIPHL Services

Screening and Referral for Co-Occurring Mental Health, Tobacco, and Trauma

SBIRT Billing and Reimbursement

Increasing Patient Access to SBIRT Services

The specific charters and details of these subcommittees can be found on the WIPHL website. If you are interested in becoming a member of a subcommittee or want to recommend someone, please contact Lilly Irvin-Vitela at (608) 263-3781 or e-mail Lilly.Irvin-Vitela@fammed.wisc.edu. She welcomes your inquiries. The subcommittees should get underway in January and will be staffed by WIPHL Coordinating Center personnel.

Finally, we will update you regarding new and continuing learning opportunities via the WIPHL All Listserv or on our website under "Learning Opportunities." There are a number of upcoming conferences and workshops concerning cultural competence as it relates to the project. A number of these opportunities offer CEUs for those of you who need them. Please feel free to contact me or Lilly for more information or technical assistance at (608) 265-4032, or e-mail Harold.Gates@fammed.wisc.edu.

A happy New Year to all of you!

Treatment Liaison Update

Improving Referral to Treatment in the New Year

By Mia Croyle

Since coming to work full time at the WIPHL Coordinating Center on December 6, one of my first tasks as treatment liaison has been to revamp the referral process. It is my hope that this revised process will be user-friendly for us all–easy to use and understand for the health educators, efficient and clear for the patients, and able to provide me with all the information I need to keep the patient engaged while I facilitate appropriate and timely treatment.

Health educators will receive information and training on this new process during the month of January. I'm anticipating that this new process, along with patients' New Year's resolutions, will greatly increase the number of patients referred to treatment in the coming months.

In the month of December we had:

- Five previously referred patients who are currently receiving treatment
- Two previously referred patients who are still in process
- Six new referrals to the treatment liaison

I look forward to working with all of you to see those numbers increase as we help people get the treatment they need in the months ahead.

Win a Pizza Party!

The federal Substance Abuse Mental Health Services Administration, SAMHSA, requires all the SBIRT projects they fund to complete follow-up on 10% of participants as a quality assurance measure. Patients who give signed consent to participate in follow-up will receive $20 for participating in a follow-up interview. For every eligible patient that signs a consent to participate in follow-up, the clinic where the patient received services will be entered into a drawing to win a pizza party. On January 31, 2008, the evaluation team will conduct a drawing from the entries and we will send an announcement out via our listserv about the winning clinic. The WIPHL Coordinating Center will also contact the winning clinic to make arrangements to purchase pizza for YOUR clinic.

The Clinic Corner

Clinics	Eligible for BS*	Completed BS	% BS Completed	Positive BS	% Positive BS	Completed FS	% FS Completed
Wave 1							
Augusta	93	33	35%	8	24%	11	138%
Eau Claire	246	79	32%	38	48%	12	32%
Northeast	306	187	61%	74	40%	52	70%
Polk County	N/A	67	N/A	32	48%	21	66%
St. Joseph's	133	110	83%	33	30%	20	61%
Wingra	140	98	70%	42	43%	23	*55%*
Totals	*918*	*574*		*227*	*40%*	*139*	*61%*
Wave 2							
Amery	N/A	97	N/A	30	31%	12	40%
FamHlt/LaCl. (0.5 FTE)	63	63	100%	13	21%	10	77%
Menominee	190	147	77%	71	48%	34	48%
St. Croix RMC	N/A	157	N/A	40	25%	26	65%
St. Croix Tribal	12	2	17%	2	100%	0	N/A
Totals	*265*	*466*		*156*	*33%*	*82*	*53%*
Wave 3							
Mercy Clinic South	339	108	32%	44	41%	18	41%
Sinai Family Care Center	86	79	92%	17	22%	15	88%
Sinai Internal Medicine	63	56	89%	16	29%	14	88%
Walker's Point	252	130	52%	48	37%	21	44%
Waukesha	271	73	27%	26	36%	20	77%
Totals	*1,011*	*446*	*44%*	*151*	*34%*	*88*	*58%*
Wave 4							
Fox Valley	231	151	65%	45	30%	28	62%
Minocqua	352	267	76%	56	21%	22	39%
St. Luke's	245	163	67%	35	21%	25	71%
Totals	*828*	*581*	*70%*	*136*	*23%*	*75*	*55%*
Grand Totals	**3,022**	**2,067**		**670**	*32%*	**384**	*57%*

*Criteria for eligibility varies by clinic

Clinic Corner/QI Commentary

By Lilly Irvin-Vitela

The numbers published in the chart above are indicators of how successfully a clinic has implemented WIPHL. This data can help QI teams identify opportunities to improve the quality of patient care. Questions that help identify such opportunities include:

1) Is everyone who is eligible to be screened for AODA and other lifestyle issues getting an opportunity to be screened?

2) Does the prevalence data of positive brief screens demonstrate the need for SBIRT services for AODA issues?

3) Do we (i.e. clinics) have systems in place that maximize the opportunity for patients who screen positive on the brief screen to meet with the health educator?

4) Are there opportunities to increase a patient's ability to receive SBIRT services?

In addition to these indicators, there are other measures in place for ensuring quality of care once a patient has met with the health educator including follow-up evaluation with 10% of WIPHL patients and monthly tape reviews.

Brief screening opportunities—Systematic brief screening is a fundamental step in creating access to WIPHL services at your clinic. In December, 61% of patients who were eligible to be brief screened at WIPHL-participating clinics received the brief screen.

Eligibility for screening varies from clinic to clinic. Generally speaking, all patients who are 18 or older are eligible to participate in WIPHL services. Clinics have made decisions to set additional limits on eligibility in order to manage patient volume or address specific patient needs. For example, clinics with a patient population that has a higher prevalence of AODA issues or co-occurring mental health needs may limit their eligibility to specific providers in order to adequately address the needs of patients. This is a strategy successfully used at UW-Wingra, where 70% of eligible patients were brief screened in December.

Clinics that have a less than full time health educator may limit their brief screening to a subcategory of patients 18 and older. For example, Family Health La Clinica has consistently demonstrated success in administering the brief screen systematically to patients by incorporating WIPHL brief screen questions into their annual health history forms. Not every patient who is 18 and older who visits Family Health La Clinica on a given day will receive the brief screen that day. New patients or those who are annually updating their health history will be brief screened at a visit. This system accomplishes two objectives: 1) It limits eligibility to patients once a year when health history forms are updated; 2) It combines the brief screening process with another successful clinic process. This creates a systematically manageable way of brief screening.

Connecting patients who screen positive with the health educator—The full screen, also known as the GPRA/ASSIST, is administered by the health educator either face-to-face or over the telephone to patients who have screened positive on the brief screen or who have been referred specifically by a physician to the health educator. Clinics have a variety of strategies for connecting patients who brief screen positive with WIPHL health educator services.

Administering the full screen is a key step in giving patients individualized, empathic, science-based interventions to create positive behavior change around alcohol/or drug risk behaviors. Prior to launching WIPHL services, clinics were asked to complete a Clinic Guide and Checklist. The questions in the checklist guided implementation teams to think very specifically about connecting patients who screen positive with the health educator. QI teams can review their approach and use PDSA cycles to meet the goal of 75% of patients who screen positive receiving services.

Just as it wouldn't be good patient care to administer a TB test and fail to read the test in a timely way and follow-up on the results of a positive TB test, brief screening patients for WIPHL but not following up on positive brief screens is less than ideal. In December, 57% of patients who screened positive on the brief screen and could have benefited from the full screen and intervention actually received services. Some of the strategies clinics have used successfully to connect patients to the health educator are:

Active hand-offs—In this strategy, the physician or MA flags a positive screen and contacts the health educator to let them know that there is a patient in the clinic who needs their services.

Clinic Corner/QI Commentary continued

Shadowing—In this approach, the health educator shadows a particular physician or physicians and conducts the brief screens face-to-face and administers the full screen when the patient brief screens positive.

Scheduling—Sometimes the health educator is with another patient and an active hand-off isn't possible. In this situation, scheduling an appointment with the health educator prior to leaving the clinic is effective. Whatever the clinic mechanism is for scheduling follow-up visits can also be an effective way to coordinate WIPHL visits. Setting an appointment within a short window of the visit in which the person was screened is key to patient engagement.

Follow-up calls—At Augusta, St. Joe's, UW-Fox Valley, and Minocqua, a significant portion of WIPHL services are delivered via telephone. These follow-up calls are an effective way of connecting with patients. At Augusta, health educator Lisa Cory was able to follow-up with patients who screened positive in December as well as patients who had screened positive in previous months. This approach does not work with every population and hasn't been as effective at most other WIPHl clinics. If connecting with patients via telephone does not work as a strategy for engaging patients in needed services, then rather than spending QI time focused on improving this strategy, it's important to adopt another strategy. Furthermore, even though follow-up calls are an effective means of service delivery, reimbursement for phone services is not likely in the near future.

Monitoring the daily patient appointment list—At Mercy Clinic South, health educator Carrie Buchen monitors the daily appointment list for returning patients who are eligible for a full screen and intervention.

If one or several of these strategies for connecting patients to health educators and WIPHL services doesn't work for your clinic, plan another strategy or set of strategies, use that strategy, and monitor your service delivery outcomes. If access to services and receipt of services increases, then adopt that strategy. If the strategy doesn't result in a different outcome, try a different strategy and complete another PDSA cycle. Quality Improvement and the use of PDSA cycles is a proven framework for improving patient services. With our shared commitment to creating access to SBIRT services, patients will benefit from the time and energy clinics devote to quality improvement.

Sign Up Now for Jan. 24 Listening Session

It's a new year—and also roughly the midpoint between our WIPHL biannual conferences.

We thought this would be a good time to have a listening session in which everybody involved with WIPHL could bring their questions, comments, or concerns to the table. The discussion will be led by clinical director Rich Brown, MD, MPH.

When: Thursday, January 24, noon to 1 p.m.
Where: At your desk! (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.

WIPHL Calendar

Health Educators Meeting, Wave 4
January 9, 9-10 am

Health Educators Meeting, Wave 1
January 9, noon-1 pm

QI/Implementation Team Coordinators Meeting
January 10, 2-3:30 pm

Health Educators Meeting, Waves 2 & 3
January 15, noon – 1 pm

Health Educators Meeting. Wave 4
January 16, 9-10 am

Health Educators Meeting, Wave 1
January 16, noon -1 pm

Cultural Competency Committee
January 18, noon – 1:30 pm

Health Educators Meeting, Waves 2 & 3
January 22, noon – 1 pm

Health Educators Meeting. Wave 4
January 23, 9-10 am

Health Educators Meeting, Wave 1
January 23, noon -1 pm

Health Educators Meeting, Waves 2 & 3
January 29, noon – 1 pm

Health Educators Meeting. Wave 4
January 30, 9-10 am

Health Educators Meeting, Wave 1
January 30, noon -1 pm

The Last Word

At least she had quit cigarettes...

From a clinic in southeastern Wisconsin

A resident happily told a health educator that, on the orders of her pulmonologist, a woman had just quit smoking cigarettes. Her pulmonologist had told her she'd be dead in two years if she didn't. The resident let the health educator know that the patient had earned some praise and encouragement.

What the HE discovered when talking with the patient is that, while she indeed had quit smoking cigarettes, each day she was smoking seven to eight blunts—a potent combination of marijuana and tobacco. Neither her pulmonologist nor the resident were aware of this. Not only was she still smoking tobacco, but the addition of marijuana made the practice even more damaging. A study published in December in the online version of *Chemical Research in Toxicology* reported that each puff from a joint contains more toxins than the average cigarette. Researchers who compared marijuana smoke to tobacco smoke found that ammonia levels were 20 times higher in the marijuana smoke, and that hydrogen cyanide and nitrogen-related chemicals also were more prevalent in the marijuana smoke.

If the WIPHL health educator had not been there to gather this vital information, her "other" smoking problem would have gone unaddressed. Thanks to our health educators for asking the right questions!

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 and Family Services (DHFS), 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.