The WIPHL Word

Wisconsin Initiative to Promote Healthy Lifestyles

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The Director's Desk

New Partnership for WIPHL and Wisconsin Medical Society

By Richard L. Brown, MD, MPH
Clinical Director

All of us at WIPHL are excited to announce a new partnership with the Wisconsin Medical Society and our move to the Society's building next month.

While the inauguration of a new formal partnership is a discrete event, our partnership with the Society has actually evolved over many years. Laura Saunders and I initially collaborated with the Society in 2004 on a Wisconsin Partnership Program planning grant to conduct statewide stakeholder meetings on SBIRT services. That project led to an implementation grant to administer SBIRT services in Polk County, and then the current SAMHSA grant.

The Society was incorporated in 1841—seven years before Wisconsin became the 30th state. With more than 12,000 Wisconsin physician members, the Society's mission is to "improve the health of the people of Wisconsin by supporting and strengthening physicians' ability to practice high-quality patient care in a changing environment." In her first few days as chief executive officer of the Society, Susan Turney, MD, attended one of our SBIRT meetings and immediately recognized the synergy in our missions.

Dr. Turney, Dr. Tim Bartholow, Nancy Nankivil, Linda Syth, and others at the Society have long supported WIPHL in arranging presentation opportunities, building relationships with providers and other organizations, and advocating for supportive policy change. They will continue to help us advance third party payer reimbursement and other policy changes to ensure that SBIRT services are sustained and expanded, both now and after our current SAMHSA grant expires. We are coordinating with the Society to offer Performance Improvement Continuing Medical Education (PI-CME) credits to physicians at our participating clinical settings. And coding and reimbursement educator Penny Osmon has been helping behind the scenes, but will soon play a much more active role in helping our clinical partners bill for SBIRT services.

Perhaps the most tangible signal of our new partnership is that we will be relocating in mid-August to the Society offices, which are on the south shore of Lake Monona in Madison. Our move will take place from August 12 to 14, and our new offices will be fully operational on August 17. In addition, on September 15 the Society will begin serving as WIPHL's fiduciary agent for the remainder of our SAMHSA grant.

WIPHL's partnerships continue with the Wisconsin Department of Health Services, the Department of Family Medicine of the University of Wisconsin School of Medicine and Public Health, and the UW Medical Foundation. We are grateful to all of WIPHL's partners, old and new, including all of our participating clinical settings, for advancing our mission to enhance delivery of SBIRT and other behavioral prevention services in Wisconsin.

This Just In:
Medicaid Reimbursement in January 2010

At a meeting in Madison on July 15, Jason Helgerson, director of Wisconsin Medicaid, announced that Medicaid reimbursement for SBIRT services will begin in January 2010. With passage of the state's biennial budget earlier this month, Medicaid had been slated to begin reimbursing for SBIRT services in January 2011. Medicaid is accelerating plans for reimbursement because of the demonstrated ability of SBIRT services to improve health outcomes, reduce healthcare utilization, and produce savings in healthcare costs. Wisconsin Medicaid is advancing SBIRT as one of many strategies to address the projected $600 million gap in its budget for each of the next two fiscal years. More details will be shared as they become available.

WIPHL Address as of August 13: ***330 East Lakeside Street, Madison, WI 53715***

Health Educator Update

VIPHL Meets WIPHL

Do Son, Vietnam, June 15–19

By Laura Saunders

Based on the well-received training that Rich gave last year in Vietnam, Pathfinders International invited him to do another training this June. Last year he was able to devote only a short time to MI-based role play, but the participants loved it. Clearly MI (motivational interviewing) needed to be a bigger part of the training this year. That's where I came in.

In his initial invitation Rich warned me that this was not going to be a pleasure cruise. He told me that the flight time was 25 hours, the weather would be "hot and humid with occasional downpours," air conditioning was "hit or miss," and while the food was tasty, it might make me sick.

As stated in Rich's "travel brochure," I arrived to find a country that at this time of the summer is bathed in hot humid air. When Rich told me that what we were experiencing was actually cooler than last year, I truly couldn't imagine it being any hotter. While our hotel rooms were air conditioned, most public spaces were not. That included stores, restaurants—and medical clinics. While we were able to escape the heat by going to our rooms, I couldn't help but wonder what the many residents who don't have air do for relief.

Food vendors along the street were plentiful. Their stands consisted of boards balancing on upturned milk crates with basins of various meats, fish, noodles, and vegetables. Dishes were washed in basins along the same sidewalks. While much of the food looked or smelled good, American intestines weren't prepared for any of it. Many Vietnamese people were enjoying the food, perched on tiny little lawn chairs. I joked with Rich that it was just as well that we couldn't eat the food as we'd have broken the chairs! All

Selling produce streetside (left). Above, Kien An outpatient clinic.

of the shopkeepers and food vendors were out from early morning until late at night, although midday heat did slow things down for a few hours of rest time around noon.

Driving from Hanoi to Hai Phong to Do Sun, I got a chance to see some of the Northern country out the windows. I loved looking at the lotus flowers and seeing the rice paddies. I also observed people carrying rubble and using sledge hammers to tear down a building, small women carrying fruit in baskets over their shoulders and people pushing carts heaped full of various things. These people did not expect or require automation to get things done. Despite the heat, they worked and worked.

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To give us an appreciation for what implementing SBIRT services in Vietnam would be like, we were given tours of two hospital settings the day before the training commenced. These settings lacked much of the privacy and comfort we expect from health care in the U.S. People waited in outdoor waiting rooms. Much of the clinic was open air and there was no privacy. Physicians have only seven to eight minutes to see the patient, and much of that time is spent filling out forms as nothing is generated by computer.

The workshop participants were a group of 30 Vietnamese physicians and a few nurses. We had four days to train them in all of SBIRT, including some understanding of MI. Based on the agreed-upon goals, workshop participants were to be able to perform and teach SBIRT. It was a tall order for four

days. With the time it takes for translation, we essentially had two days of talk time!

The participants themselves were certainly a highlight of the training. They were open to this training and want to do whatever they can for their patients. They worked hard to understand SBIRT, as was evidenced by their questions and performance in small group activities. Based on several MI exercises and what we knew about our group, we made up a badminton game for the start of our final morning. Points were awarded by the impartial judges (Rich and I). This game was so spirited and so filled with energetic (and often scathing) competition and teachable moments that it went on for two hours.

Our workshop concluded with a "What next" exercise. We split them into groups by site and asked them to plan their next steps. There were larger groups from each of two hospitals in Hai Phong and three physicians who were the single representatives from their respective medical colleges. All of the groups were able to put together a comprehensive plan that addressed knowledge, skill, and attitudinal changes. They were well on their way to using MI to deliver health care.

Vietnam is halfway around the world from us. While we look different from one another (nobody had red hair, that was for sure!), we don't speak the same language, and our worlds are very different in terms of development, what we have in common is our desire to help people.

More street vendors (left). Above, Rich Brown and Laura Saunders out with colleagues.

It is my hope that by helping our Vietnamese colleagues tap into their skills and knowledge around facilitating behavior change in their patients, we made a contribution. While there is very little money for such things as medications, equipment, or procedures, we SBIRT practitioners know how much can be accomplished with just two people talking. The cost is next to nothing, but the returns are great.

Project Manager Update

Sustain and Enhance WIPHL

By Candace Peterson, Ph.D.

Here we are, poised at the edge of Year 4 of SBIRT services in Wisconsin. This is an exciting and busy time at WIPHL Central. In addition to supporting our clinical sites in delivering SBIRT, several projects focus on sustaining and/or enhancing these services:

1. Sustaining the delivery of SBIRT services—Coordinating efforts to promote the understanding and support of SBIRT services among health care providers, health care purchasers (those in the business sector who purchase health care), health care payors (the insurance sector, whose plans may reimburse providers for SBIRT services), and those in the public sector who make policies and create procedures for Medicaid/Medicare reimbursement for SBIRT services. Our growing partnership with and physical move to the Wisconsin Medical Society in August is part of these efforts.

2. Enhancing SBIRT services—Enlisting the able assistance of Dr. Randy Brown in further educating our clinical partners, starting this fall, about pharmacotherapy for substance use disorders. Dr. Brown is an assistant professor with the Department of Family Medicine, UW School of Medicine and Public Health. (He is not related to WIPHL's Rich Brown!)

3. Improving SBIRT services—Working with an evaluation team from the Population Health Institute, UW School of Medicine and Public Health, to conduct a "State of the WI SBIRT Project" evaluation as well as a "best practices in SBIRT" evaluation. The latter will help us understand the many factors that go into successful SBIRT implementation in a clinical setting, including clinic identification and recruitment, service launch, and service delivery.

4. Sustaining, Enhancing and Improving SBIRT Services—Working with Kevin Browne (Midwest Center for Cultural Competence) to assess organizational cultural competence at the WIPHL Coordinating Center, i.e., look at our policies, environment, materials, procedures, and programs with an eye to cultural competence.

Many of you will be involved in these efforts in one capacity or another. Your involvement is a big reason why Wisconsin is looked upon as the leader in SBIRT innovation. To you we say "thank you!" in advance; as always, working with our partners increases our yield in all of these efforts.

Treatment Manager Update

Just Imagine: Patient-Centered Care

By Mia Croyle

A recent article in the *New York Times* on patient-centered care (http://www.nytimes.com/2009/06/04/health/04chen.html?ref=health) caught my eye and really got me thinking about what might be different about our specialty addiction treatment system if it were designed using these principles of patient-centered care. This article proposed that truly patient-centered care would mean a transfer of control from doctors (or treatment providers) to the patients themselves. Shared decision-making would be mandatory and the patient would be the source of control. This is very aligned with the principles of motivational interviewing.

This issue is especially salient for me right now because our program has had several instances where patient-centered care would have been relevant and helpful. We have had patients not being able to enter the level of care that they felt would be most helpful because they were not deemed "clinically appropriate" for that level of care; patients have left treatment programs against medical advice; and patients have been administratively discharged due to "non-compliance."

It seems to me that these issues are all connected to the fact that the patient is not the primary decision-maker in the specialty addiction treatment system. An ideal practice would be one of which its patients would say, "They give me exactly the help I need and want exactly when I need and want it." Would patients say this of the specialty addiction treatment system in its current structure?

I am fully aware of the multiple constraints on our current specialty addiction treatment system. There are financial, legal, and social considerations. The system has the unenviable challenges of managing and allocating scarce financial resources, of keeping both patients and the public safe, and of deciding who gets what services and when.

In 2007, 23.2 million Americans needed addiction treatment but only 10 percent were able to receive it. Untreated addiction has severe consequences—for individuals, families, communities, and for our society as a whole. I certainly don't have the answers, but I believe that imagining a better way can be an important first step.

Cultural Competence Update

New Directions in CC at WIPHL

By Harold Gates

As we move into Year 4 of the Wisconsin Initiative to Promote Healthy Lifestyles (WIPHL), our cultural competence efforts are transitioning as well. We had our initial meeting of the "new" Cultural Competency Committee on June 19. The committee has evolved into a steering committee and is open to representatives of all of our WIPHL clinics. We have also invited members of the Governor's Policy Committee and various subcommittees, as well as the SCAODA Diversity Committee. This composition will give us the people who can help us chart the project's cultural competence principles and address healthcare disparities relevant to our patient populations around the state of Wisconsin.

Our new direction will take place in three parts. First, we have contracted with Kevin Browne of the Midwest Center for Cultural Competence to conduct a cultural competence organizational audit for WIPHL Central. The audit will look at such things as mission/vision, human resources policies and practices, partnerships, fiscal resources, clinical services, evaluation, technical services, and education and training. The findings of the cultural competence audit will give us valuable information for this important part of our organization as well as help us set some short- and long-term goals in this area.

Second, we will also be looking at ways to continue to offer cultural competence training to fit the needs of our health educators. This will include the use of the California Brief Multicultural Competence Scale (CBMCS) and discussion of relevant topics for HE teleconferences and HE retreats. We will also be researching online training options such as webinars and videos that can be accessed as health educators' schedules allow. One example is the website "Cultural Competence Online for Medical Practice" (www.c-comp.org/), which is sponsored by the University of Alabama at Birmingham's School of Medicine. This site is geared to cardiovascular disparities but includes such features as a "cross-culture bridge" and resources that help us understand implications for African Americans generally as well. The other website I found is www.counselormagazine.com. *Counselor: The Magazine for Addiction Professionals* is a national peer-reviewed publication that blends the in-depth information often found in journals with the reading ease and style of a magazine. *Counselor* also allows for online training with CEs related to quizzes in each issue. I would encourage you to review both these websites for the purposes of your continuing professional development.

Third, we would like to invite one or two WIPHL clinics to complete a cultural competence audit/needs assessment and pilot a focus on stigma and/or related cultural issues. This could, among other uses, offer feedback to clinics on the demographics of patients served compared to overall clinic demographics. If you are interested in serving on the committee and/or have questions about your involvement, you can reach me at 608-265-4032 or via e-mail at Harold.Gates@fammed.wisc.edu.

Month End Data

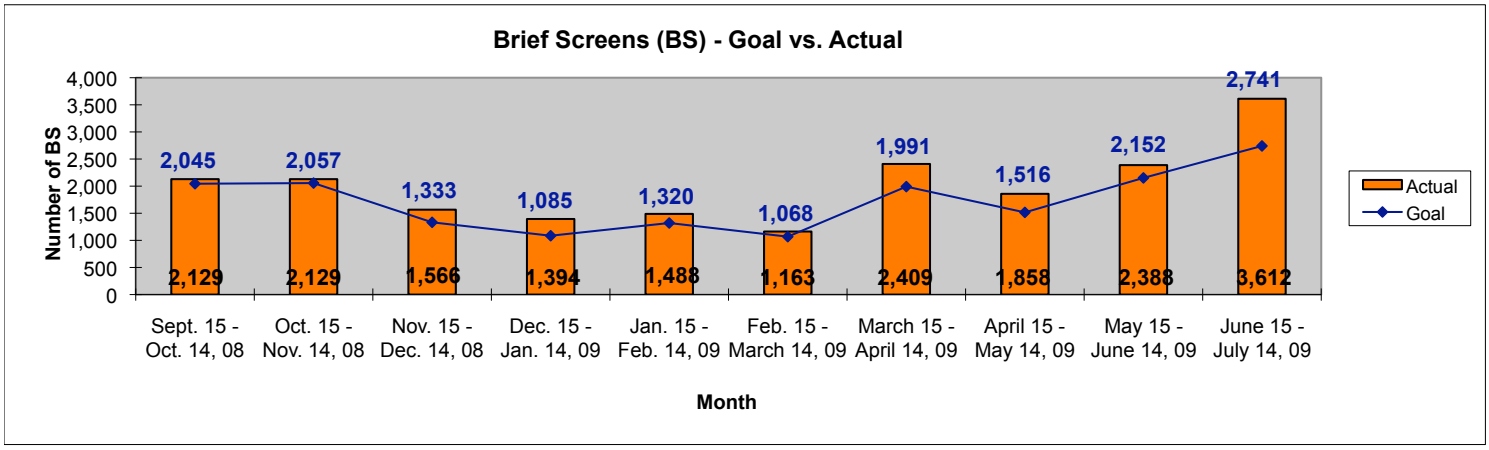
June 15 – July 14, 2009

Clinics	*Eligible for BS**	*Completed BS*	*% BS Completed*	*Positive BS*	*% Positive BS*	*Completed FS*	*% FS Completed*
Amery Regional Medical Center	111	98	88.3%	42	42.9%	40	95.2%
Aurora Family Care Center	125	115	92.0%	35	30.4%	33	94.3%
Aurora Mayfair (0.5 FTE)	155	148	95.5%	33	22.3%	26	78.8%
Aurora Sinai Women's Health Center	118	102	86.4%	29	28.4%	28	96.6%
Aurora Walker's Point	270	268	99.3%	78	29.1%	77	98.7%
Beloit Area Community Health Center	470	446	94.9%	138	30.9%	125	90.6%
Columbia St. Mary's	399	249	62.4%	77	30.9%	45	58.4%
Dean - East	416	416	100.0%	110	26.4%	102	92.7%
Dean - Sun Prairie	287	239	83.3%	106	44.4%	75	70.8%
Family Health/ La Clinica (0.5 FTE)	133	133	100.0%	19	14.3%	12	63.2%
Marshfield - Park Falls/ Phillips	209	169	80.9%	44	26.0%	32	72.7%
Menominee Tribal Clinic	N/A	339	N/A	75	22.1%	34	45.3%
Milwaukee Health Services, Inc. (0.3 FTE)	14	14	100.0%	10	71.4%	7	70.0%
Scenic Bluffs Community Health Center (0.2 FTE)	19	18	94.7%	3	16.7%	1	33.3%
St. Joseph's Community Health Services - Adults	149	148	99.3%	46	31.1%	40	87.0%
St. Joseph's Community Health Services - Adolescents	18	18	100.0%	3	16.7%	3	100.0%
Upland Hills Health	93	91	97.8%	23	25.3%	21	91.3%
UW Health - Northeast	342	298	87.1%	108	36.2%	67	62.0%
Waukesha Family Practice Center	327	303	92.7%	88	29.0%	80	90.9%
Grand Totals	**3,655**	**3,612**	**98.8%**	**1,067**	**29.5%**	**848**	**79.5%**

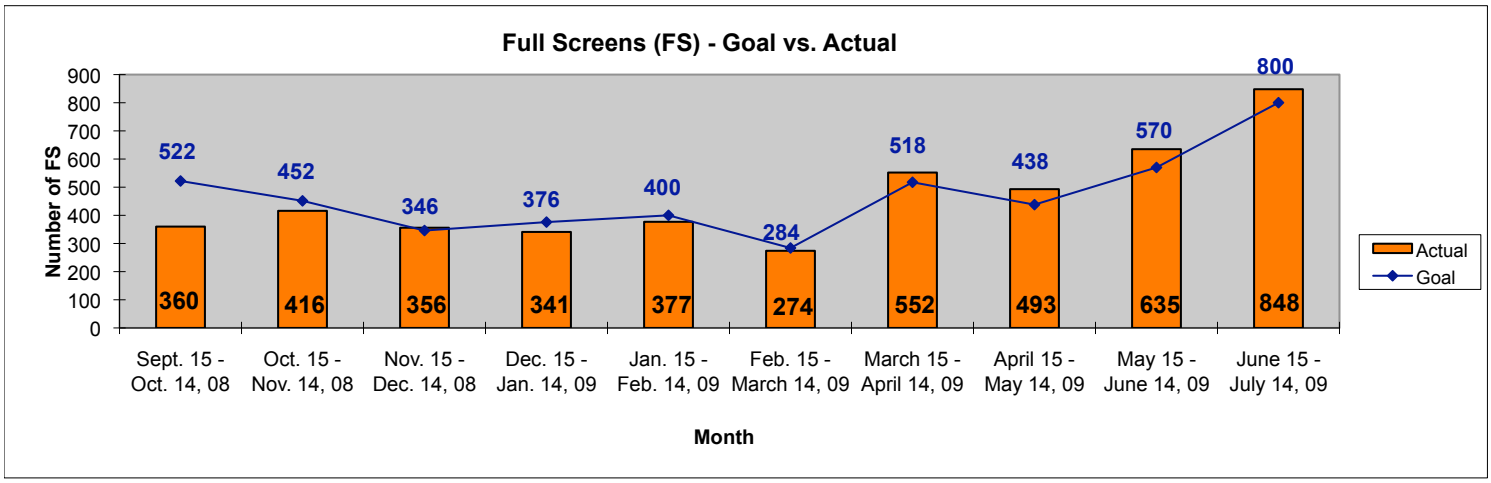
*Eligibility varies by clinic

Data in this and accompanying charts compiled by Jessica Wipperfurth

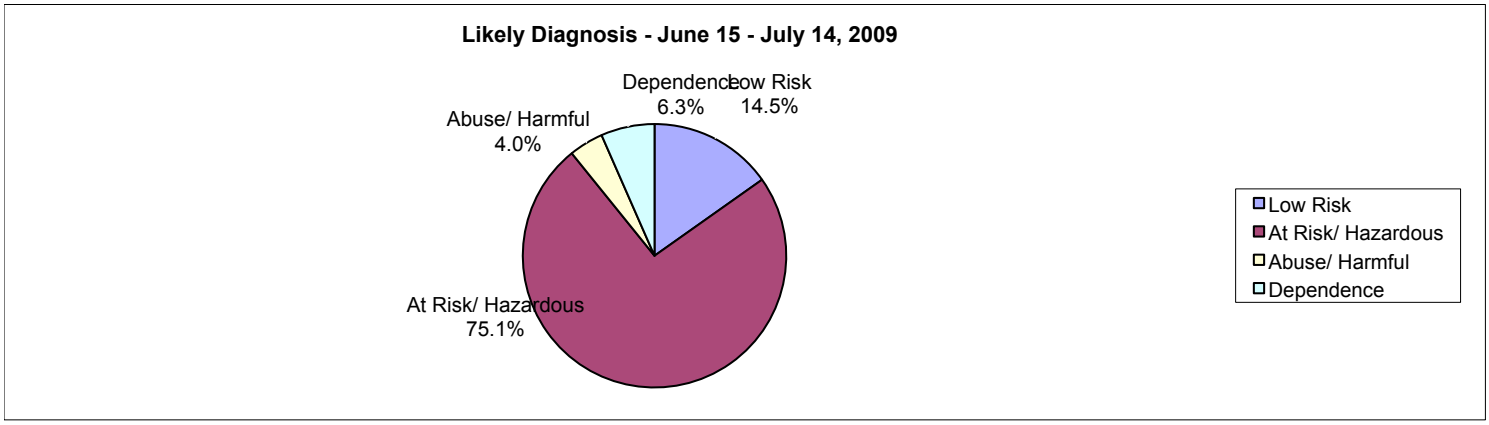
Year-to-Date Data



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



Actual: Number of full screens completed
Goal: Year 3 (June 15 - Sept. 14, 2009) - P4P Clinics: Full screen 75% of patients who brief screen positive
Goal: Year 3 Quarter 3 Goal (June 15 - Sept 14, 2009) - WIPHL Funded: Full Screen 150 patients per clinic (prorated based upon % FTE)



Calendar

July 28, Governor's Policy Subcommittee Meeting, Access for Adolescents, 11 a.m.-12 p.m.

July 30–31, Health educator retreat, Madison

August 10, Governor's Policy Subcommittee Meeting, Promoting Demand, 1-2 p.m.

For other health educator meetings and additional information about events, see www.wiphl.org

SAVE THE DATE: STATEWIDE MEETING OCTOBER 5-6 IN MADISON

The Last Word

"Without my health educator and my doctor, I would have died"

From a patient in southern Wisconsin:

For a period of nearly three years, I was addicted to prescription medications. I am a middle-class mother of young children. I am married to a doctor and am a healthcare professional myself. This wasn't supposed to happen to me. But I am living proof that it can happen to anyone. To this day no one in my family, not even my husband, knows the extent of my drug problem.

I began taking Vicodin when I suffered some orthopedic injuries. But I got to a point where I knew I wasn't taking it for the physical pain anymore. I just liked the feeling and began finding it hard to function without it. After the physician quit prescribing the pills, I found myself looking for other ways to get them.

I went from Vicodin to oxycodone. Eventually I was up to 5-6 pills a day. Since they cost $40 a pill, this was a very spendy habit.

I saw myself changing in ways that I didn't like at all. I went from being a very sociable, outgoing, athletic, happy individual to not wanting to go anywhere, not wanting to do anything, just constantly focusing on getting and taking these drugs. It took over my life. I had to make sure I had those medications because if I didn't, I knew I'd go through withdrawal and get sick.

As many times as I tried to quit on my own, I couldn't do it. I finally decided enough was enough, and I went over to my primary care clinic to ask for help. Inpatient treatment was not an option because of privacy issues and because I have a family and a life that I can't walk away from.

I went in there so embarrassed about telling people, to admit what I was doing, let alone how much I was doing. I sat down and talked with my health educator and we did an assessment interview to find out what was going on. I of course was classified as addicted.

My primary care doctor prescribed suboxone to help with my physical addiction, but there's still the mental part, and that's what my health educator helped me with. I had to learn how to live without drugs, how to deal with the challenges and triggers and temptations I faced many times each day. Many of the things my health educator said came back to me when I needed them most. I didn't want to seek extensive counseling—I had all kinds of excuses. My health educator put together a list with a number of options, and I was able to find something that fit.

I do know this: Without her and my doctor, I would have died. I'm finally starting to get my life back, and I love it. I love being who I was before. I couldn't have done it without these two people. There's just no way.

I hope this helps other people. That's why I'm telling my story.

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 (Department of Family Medicine) and the Wisconsin Medical Society. Readers are encouraged to send suggestions and submissions to editor Joan Fischer at Joan.Fischer@fammed.wisc.edu.