The WIPHL Word

Wisconsin Initiative to Promote Healthy Lifestyles

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The Director's Desk

WIPHL Prepares for Year 4

By Richard L. Brown, MD, MPH
Clinical Director

In about three months—on September 15, to be precise—WIPHL will begin its fourth and penultimate year of SAMHSA funding. Over the last few years, WIPHL and its trailblazing clinical partners around Wisconsin have accomplished a lot. We've delivered over 60,000 screens and 10,000 brief interventions. To answer naysayers who believe that patients won't discuss their drinking and drug use, our health educators have elicited high patient satisfaction scores for their services. Our six-month follow-up interview data are demonstrating reductions in risky drinking (also known as binge drinking). Wisconsin is showing that SBIRT can work in a wide variety of clinical settings both public and private, large and small, including primary care clinics and emergency departments; urban, suburban, and rural locations; sites that serve many disadvantaged and minority patients; and even residency training sites.

For the remainder of our grant funding period, which expires in August 2011, we have two major goals. One is to continue delivering high-quality services to large numbers of patients—about 50,000 patients who have not previously received SBIRT services. I expect that the ever-expanding volume of service delivery at many of our longtime clinical partners and the recent addition of several new clinical settings will bring success in this realm.

The other goal is to make SBIRT service delivery sustainable, meaning that services will continue long after our SAMHSA grant expires. None of SAMHSA's seven previously funded states have accomplished this. And we've already made more progress than most here in Wisconsin.

Ten of our predominant private payers will reimburse for SBIRT services. We are grateful that Governor Doyle has included funds in his budget proposal so that Medicaid can expand its SBIRT coverage from pregnant patients to all patients. The Wisconsin Medical Society will be working closely with WIPHL to advocate for reimbursement by all of our state's dominant private payers. We expect that almost all of our current clinics will be able to start billing at least some payers for SBIRT services in 2010.

Preparing to bill will take significant work by the WIPHL central staff and especially our clinical partners. The Medical Society's billing specialist, Penny Osmon, who has already been so helpful to WIPHL, will help us update our billing manual, conduct webinars, provide phone consultation, and visit clinical settings as necessary. Clinical settings will need to have standing orders and other documentation on file. Documentation that's generated by health educators will need to be co-signed by credentialed providers and placed in medical records. Clinical settings may wish to make handouts for patients to describe the billing implications of receiving SBIRT services. We'll probably discover the need for more work as we go.

In addition to the concrete support we and the Medical Society will be providing, we're proposing for Year 4 that WIPHL fund 90% of health educators' compensation.

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Private clinical settings would fund the remainder through billing. We expect that most if not all settings will generate revenue in excess of 10% of their health educators' compensation, which will be just reward for their hard work to get billing off the ground. Our publicly funded clinics—community health centers and one tribal clinic—may need a more creative approach. They are funded much more through grants and contracts than billing and reimbursement. We hope to help them start finding other sources of funding that will eventually replace their WIPHL funding.

Year 4 is where the rubber meets the road for WIPHL. Our goal is that each of our clinical partners starts Year 5 with clear and demonstrated potential for sustainability. I'm committed to ensuring that our current SAMHSA funding turn out to be not just another grant that comes and goes but merely the beginning of a statewide revolution to make SBIRT services and other evidence-based, cost-saving behavioral prevention services a routine part of health care.

It's taken so many partners to get WIPHL where it is. It will take even more partners and more hard work to make SBIRT services sustainable in Wisconsin. Thanks so much to everyone around Wisconsin, in Washington, and beyond who is making this possible for our patients, for their families, and for all of our communities.

Health Educator Update

An Inspirational Week

By Laura Saunders

Earlier this month, I attended the Motivational Interviewing Network Trainers Forum in Barcelona. This international group of MI trainers provides an opportunity to stay current with the MI literature and training exercises. It is also a great place to network with other trainers.

Drs. William Miller and Steven Rollnick delivered the keynote address on Ten Defining Characteristics of Motivational Interviewing. Below is the list and a few of the notes that I found most inspiring. What do you think?

1. MI is a collaborative style of communication. It is not a method or a technique, but an overall style.

2. MI has a particular focus—change.

3. MI has a particular purpose: to elicit and strengthen personal motivation for change. It is the MI therapist who calls forth that which is already present in the patient.

4. MI is person-centered by honoring autonomy and self-determination. MI practitioners accept that they can't fix the individual. You can't really take away a person's choice, so having a conversation about it is better than saying, "You can't."

5. MI applies specific helping skills in prescribed ways.

6. MI moves toward a particular change goal.

7. MI is attuned to and guided by particular aspects of client speech.

8. MI is brief.

9. MI is adaptable. MI is not formulaic but responds to the person's immediate experience.

10. MI is learnable. Proficiency in MI involves using specifiable skills that are strengthened with practice. MI is not vague niceness, but particular observable and learnable skills. The quality of MI sessions is quantifiable.

In closing, Dr. Miller reminded us that MI is a powerful ingredient in the fuel that drives practice. While it is not the only style for helping people, it is one that, by all accounts, seems to work really well.

Cultural Competence Update

Someone You Might Know

By Harold Gates

Last month I kept seeing a familiar name in the news—and, eventually, in the obituaries as a surviving family member. This acquaintance of mine is the daughter of a woman who recently had been killed by her ex-husband. A few days later, I was driving though town and was surprised to see several blocks of a normally quiet neighborhood blocked off by police. I was thinking that something very wrong must be happening. As I learned on the news that evening, the ex-husband had killed himself in a park in that neighborhood after running from the law. I thought to myself how awful this all was and how tragic. That week I went to the woman's visitation and was able to offer some support to her daughter.

The scenario is all too familiar and brought home the hard facts of a pamphlet produced by the Victim Outreach Committee of a task force of the Dane County Commission on Sensitive Crimes. The information was designed to help professional therapists and treatment providers discern if domestic abuse is present in families that they are or will be treating. It also helps treatment providers decide if domestic abuse counseling should be part of their practice or if they should refer clients to other professionals. (Dane County Commission on Sensitive Crimes, July 2008)

Much of the booklet is devoted to exposing the "myths" of domestic abuse and providing corresponding facts. Here are some excerpts:

Myth 1: I can do anger management counseling with perpetrators of domestic abuse.

Fact: Anger management counseling undermines attempts to hold domestic violence abusers accountable and places their victims at greater risk.

Myth 2: Abuse is only dangerous when it is physical in nature.

Fact: Domestic violence includes all controlling behaviors such as intimidation, isolation, emotional cruelty, economic abuse, sexual exploitation and threats.

Myth 3: Relationship problems cause domestic violence.

Fact: Improving the relationship will not stop violence. The abuser is the only person responsible for the violence. Victims are not to blame for the abuser's conduct.

Myth 4: Couples counseling is an effective way to treat domestic abuse.

Fact: Couples counseling is not effective because the victim may not be able to speak freely or honestly with the abuser present.

Myth 5: Women in relationships are as aggressive as men.

Fact: Women tend to commit violence less frequently than men and for different reasons. Women may initiate violence for self-protection or retaliation.

Myth 6: Only children who directly experience abuse are affected by it.

Fact: Children who witness abuse display as much or more physical or verbal aggression, sleep disturbance, and anxiety as those who are direct recipients of abuse.

Myth 7: Alcohol or other drugs cause domestic abuse.

Fact: Alcohol and other drugs can escalate abuse, but they do not cause a person to be abusive. Under the influence, abusers may have fewer inhibitions, and abuse tends to be more violent.

Myth 8: Victims of abuse should just leave.

Fact: Leaving is the most dangerous time for victims. They are 70 percent more likely to be murdered by their partner after leaving.

Copies of this valuable resource are available at the Dane County District Attorney's Domestic Violence Unit, tel. 608-284-6880. Some excellent websites to review are Domestic Abuse Intervention Services, www.abuseintervention.org, tel. 608-251-4445, and the Wisconsin Coalition Against Domestic Violence, www.wcadv.org. This site offers information on programs that are certified by the Wisconsin Batterers Treatment Providers Association.

As always, if you need cultural competence technical assistance, you can reach me at 608-265-4032 or via e-mail at Harold.Gates@fammed.wisc.edu.

WIPHL People

This month we catch up with introductions and one farewell at the WIPHL Coordinating Center.

Celeste Hunter, MS, CRC

Celeste joins WIPHL as a research assistant. She earned her bachelor's degree in education from Eastern Washington University and taught special education for more than eight years before obtaining a master's degree in rehabilitation psychology from the University of Wisconsin-Madison. Upon graduation, Celeste conducted clinical research with the University of Washington's Multiple Sclerosis Research and Rehabilitation Training Center in Seattle using motivational interviewing (MI) to promote exercise and job retention among people with multiple sclerosis. Currently she is completing her doctorate in rehabilitation psychology from UW-Madison. She is passionate about enhancing people's motivation to engage in healthy lifestyles.

Celeste will work alongside WIPHL's Site Implementation Team to enhance MI coaching that is offered to our health educators. She also hopes to better understand and identify potent elements within service delivery that may increase people's likelihood to change. Results from this research have the potential to guide the design and implementation of new services to be offered to alcohol-dependent patients in WIPHL settings.

Bill Merrick

Bill is a student at the University of Wisconsin, where is studying economics and psychology. He joined the WIPHL team as an intern in December 2008 and until recently worked primarily on data entry. His current projects include updating the WIPHL blog site, developing flow sheets and Excel spreads to outline the new depression treatment tablet software, and finishing up remaining data entry. Bill is an avid outdoorsman, car enthusiast, and local DJ. He plans to continue working with the WIPHL team through the fall semester.

Brent Ruehlow, MSW

We bid farewell and extend our thanks to Brent Ruehlow, who began with WIPHL as a social work intern in July 2008 and leaves us this month. His activities included shadowing health educators, which gave him a clear picture about what takes place in clinics and the role that motivational interviewing (MI) plays in the success of patient interactions; researching the correlation between AODA treatment for parents/caregivers and the effect that interventions (or lack of interventions) have on their children; participating in MI trainings; and assisting with the transcription and feedback of HE and patient sessions.

Brent found his experience with WIPHL very valuable. "Being able to see the development and implementation of the adolescent protocol and subsequent interviews with teenagers was amazing, as the brief intervention was clearly causing a shift in thinking," he says. "My experience at WIPHL was tremendous and the learning experiences are too numerous to list. I truly appreciate the vision and passion that WIPHL has for SBIRT services and the work that is conducted for patients and families. Additionally, seeing the spirit of MI at work throughout my internship was a refreshing look at how we should all work with people."

We wish Brent all the best in his studies and future work experience.

Month End Data

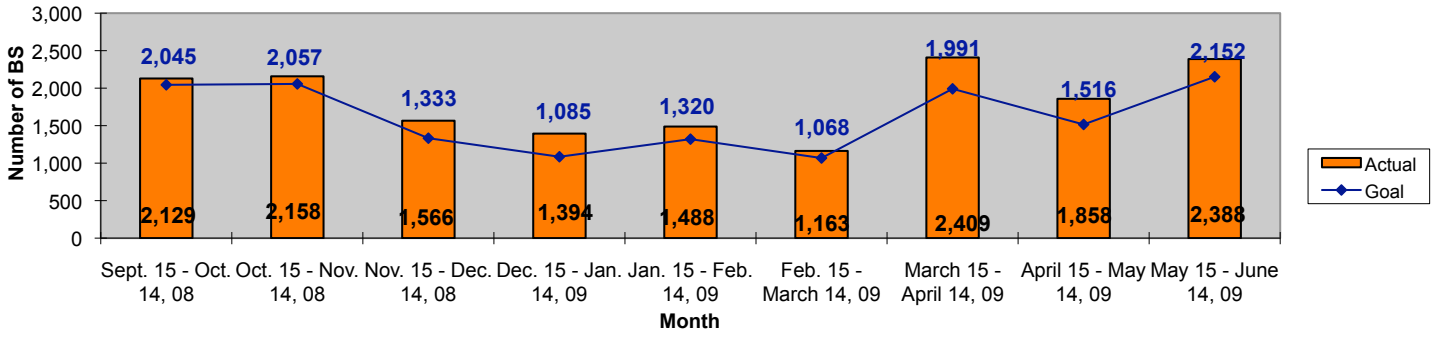
May 15–June 14, 2009

Clinics	*Eligible for BS**	*Completed BS*	*% BS Completed*	*Positive BS*	*% Positive BS*	*Completed FS*	*% FS Completed*
Amery Regional Medical Center	129	121	93.8%	47	38.8%	46	97.9%
Aurora Family Care Center	125	115	92.0%	45	39.1%	40	88.9%
Aurora Mayfair (0.5 FTE)	131	128	97.7%	26	20.3%	21	80.8%
Aurora Sinai Women's Health Center	9	9	100.0%	4	44.4%	3	75.0%
Aurora Walker's Point	317	316	99.7%	77	24.4%	71	92.2%
Beloit Area Community Health Center	133	130	97.7%	34	26.2%	29	85.3%
Columbia St. Mary's	115	64	55.7%	18	28.1%	14	77.8%
Dean - East	62	62	100.0%	18	29.0%	16	88.9%
Dean - Sun Prairie	361	292	80.9%	115	39.4%	92	80.0%
Family Health/ La Clinica (0.5 FTE)	146	146	100.0%	49	33.6%	45	91.8%
Marshfield - Park Falls/ Phillips	100	84	84.0%	32	38.1%	14	43.8%
Menominee Tribal Clinic	413	125	N/A	47	37.6%	51	108.5%
Milwaukee Health Services, Inc. (0.3 FTE)	8	6	75.0%	4	66.7%	6	150.0%
Scenic Bluffs Community Health Center (0.2 FTE)	21	21	100.0%	6	28.6%	1	16.7%
St. Joseph's Community Health Services - Adults	164	161	98.2%	41	25.5%	37	90.2%
St. Joseph's Community Health Services - Adolescents	13	13	100.0%	4	30.8%	1	25.0%
Upland Hills Health	111	108	97.3%	41	38.0%	39	95.1%
UW Health - Northeast	190	186	97.9%	69	37.1%	47	68.1%
Waukesha Family Practice Center	321	301	93.8%	83	27.6%	62	74.7%
Grand Totals	**2,869**	**2,388**	**83.2%**	**760**	**31.8%**	**635**	**83.6%**

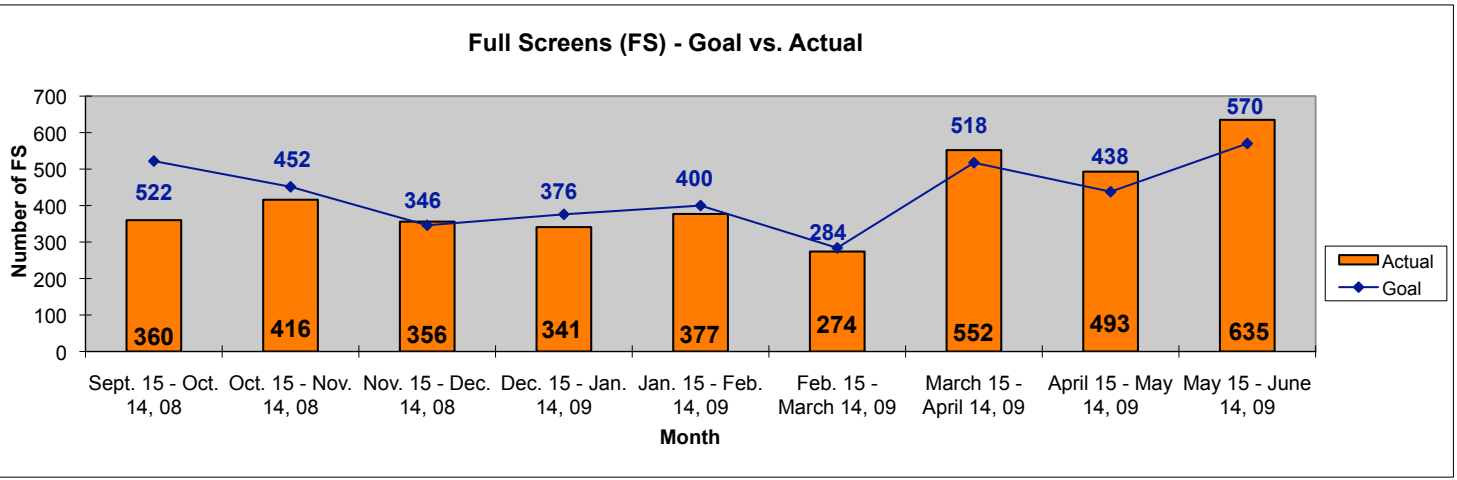
*Eligibility varies by clinic

Data in this and accompanying charts compiled by Jessica Wipperfurth

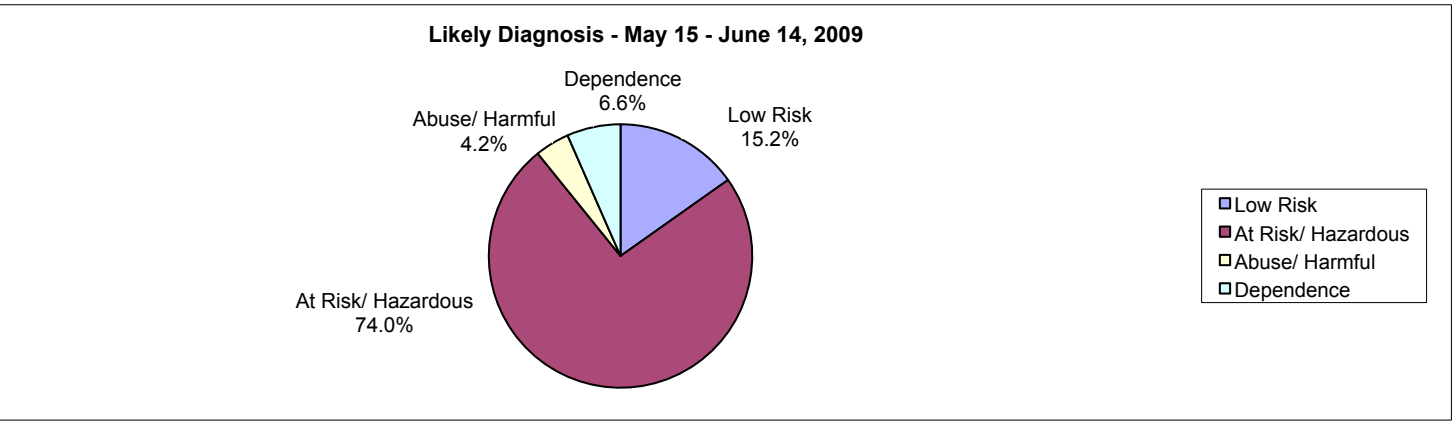
Year-to-Date Data



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



Actual: Number of full screens completed
Goal: Year 3 (March 15 - June 14, 2008) - P4P Clinics: Full screen 75% of patients who brief screen positive
Goal: Year 3 Quarter 3 Goal (March 15 - June 14, 2008) - WIPHL Funded: Full Screen 135 patients per clinic (prorated based upon % FTE)



Calendar

June 19
Cultural Competency Committee meeting, 12-1 p.m.

June 25
Governor's Policy Subcommittee Meeting,Access for Adolescents, 11 a.m.-1 p.m.

July 30–31
Health educator retreat, Madison

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

The Last Word

"I would have died without WIPHL"

From a patient in central Wisconsin:

A patient we'll call Mary describes her life as "a living hell" before she found help through WIPHL.

"I was isolated and wishing I was dead. I didn't want to be around other people because of my habit. I didn't know where I was going or what I was doing."

She was drinking at least six beers a day. "And I was taking pills, too—whatever I could get, wherever I could get them, so that I wouldn't feel the pain."

She finally hit bottom when her live-in boyfriend kicked her out of their house because of her substance abuse and told her if she didn't get professional help, they could no longer be together. Mary had long known that she needed help, but didn't know where to find it.

"I made phone call after phone call after phone call, and everybody that could or would help me told me I needed to have money or insurance."

Finally Mary decided to see her GP—"I figured they could give me some kind of referral"—and that's when she found WIPHL. The full screen experience was upsetting to her because it revealed the extent of her drinking and drug dependence. But she found her health educator enormously comforting. Working with the WIPHL treatment manager, she entered and successfully completed a residential treatment program.

"My life is better now in every sense of the word. I can now enjoy life. I can love and be loved," says Mary, who suffered from physical and sexual abuse as a child. "Feeling free is the most amazing thing. I've never been free in the sense of being able to express myself as a person. I could never talk in front of people. I was a hermit."

Her attitude and interpersonal skills have changed so dramatically that she was recently named Employee of the Month at her workplace—something she swears never would have happened in the past.

Where would she be if not for WIPHL? Mary doesn't have to think long to answer that question. "I would be dead, I'm sure of that. I had wished myself dead so many times."

She thanks WIPHL for helping her find a life worth living.

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.