The WIPHL Word

Wisconsin Initiative to Promote Healthy Lifestyles

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The Director's Desk

SBIRT Momentum Continues

By Richard L. Brown, MD, MPH
Clinical Director

After four years of WIPHL, I wonder: Do I see the whole world through the lens of SBIRT, or have there been yet two more exciting national developments in support of our work?

One is a U.S. Department of Health and Human Services (DHHS) proposal for a department-wide initiative on multiple chronic conditions (http://www.hhs.gov/ophs/initiatives/mcc). The initiative comes from the realization that the 27% of Americans with multiple chronic diseases generate 66% of all health care costs. As part of the recently passed health care reform bill, the initiative aims to stimulate research and improve service delivery for these patients. The proposal recognizes that "self-care management can be important in managing risk factors that lead to the development of additional chronic conditions."

"The initiative comes from the realization that the 27% of Americans with multiple chronic diseases generate 66% of all health care costs"

Of course, such risk factors include tobacco use, excessive drinking, and drug use. Attention to depression also will be key, as depression is prevalent among patients with chronic diseases and hinders all-important self-management. And of course, in the best of all worlds, systematic behavioral screening and intervention would prevent a lot of chronic disease in the first place.

The other welcome development is the National Committee on Quality Assurance (NCQA) proposal on new standards for "medical homes" (http://www.ncqa.org/tabid/1196/Default.aspx). While the precise definition of medical home remains vague and controversial, the concept clearly embraces improving primary care through "systematic, patient-centered, coordinated care management processes." A proposed new element is systematic screening for tobacco use, substance use, mental health, diet, and physical activity for patients and their families. It was also good to see a new requirement for cultural competence.

While the proposals are steps in the right direction, I do believe that they could go farther in promoting delivery of evidence-based interventions. I encourage you to visit each of the above websites and comment on the proposals, as I did. In the meantime, it's great to witness that increasing numbers of key organizations view attention to behavioral issues as integral to excellent health care.

Project Manager Update

Cultural Competence Begins at Home

By Candace Peterson, PhD

Racial and ethnic disparities in health care persist despite considerable progress in expanding health care services and improving the quality of patient care. Many factors contribute to these disparities in complex ways: differences in patients' preferences and health-seeking behavior; clinical encounters; stereotypes and biases; and aspects of health systems, such as changes in financing and delivery of health care.

Across the nation, the goal of health system administrators and managers and health care providers is to provide high quality health care products and services to *all patients*. They work hard, under very challenging conditions, to ensure that an increasingly diverse patient population receives the best possible health care to meet their needs.

Why do these health care disparities exist, when health systems and health care professionals have dedicated themselves and work hard to provide the highest possible quality of care to all patients? It's a nationwide problem.

Looking closer to home, we need to ask ourselves: Do disparities exist in WIPHL's SBIRT services? And if so, what can be done to reduce disparities?

WIPHL's goals are to 1) consistently deliver efficient, quality SBIRT services, and (2) make behavioral prevention services routine in Wisconsin health care settings. To meet these goals, we strive to promote high quality care for all patients by including cultural competence as one of the guiding principles of the SBIRT project. We believe that achieving equity is an essential part of quality improvement in SBIRT service delivery. To do this, the first step is to increase our—WIPHL Central's and WIPHL partners'—awareness about disparities, i.e., to identify and help address any existing disparities in SBIRT service delivery.

WIPHL is fortunate to be working with the University of Wisconsin Population Health Institute (PHI) staff as the evaluator of the WIPHL SBIRT program. Staff from PHI have been involved in the WIPHL project from its inception. PHI has recently completed an overview of data collected from the beginning of the SBIRT project though early May 2010. The PHI team is preparing a report for each WIPHL clinic, due out next month, which presents information on clinic population demographics compared to demographics of clinic patients who have received SBIRT services. Harold Gates, WIPHL's associate director of Cultural Competence, together with other WIPHL staff, will follow up with each of our clinical site partners to discuss results and to recommend resources for best practices and strategies to reduce any disparities in SBIRT services.

The report also presents information about SBIRT outcome data across all clinics, that is, changes in substance use patterns after receiving SBIRT services, and about patients' perceived usefulness of the WIPHL program in helping them to change/modify lifestyle in areas of patients' concern. There is encouraging information in these reports, both in terms of patient outcomes and patients' perceptions about SBIRT services. Each WIPHL clinical site will receive a report that has been tailored for their site. Look for more information on this in the next WIPHL Word.

Cultural Competence Update

New Thinking in Cultural Competence

By Harold Gates

While reading a recent edition of *Academic Medicine* (Vol. 85, No. 4/April 2010), I was particularly intrigued by "Linking Cultural Competence Training to Improved Health Outcomes: Perspectives From the Field." Drs. Joseph R. Betancourt and Alexander R. Green describe the evolution of cultural competence education as moving beyond the "categorical approach," which means teaching about the attitudes, values, beliefs, and behaviors of specific cultural groups, such as Latino patients. While they feel this method could be helpful to clinicians, being presented with and learning a set of specific cultural beliefs and behaviors that are attributed to a particular group could lead to stereotyping and oversimplification of a culture rather a respect for its complexity.

According to the authors, cultural competence has moved from the categorical approach to a skills-based approach. This means that cultural competence now focuses more on developing a set of skills and a framework that allows the clinician to assess what might affect that individual patient's care. One particular skill that can be developed under this model is the use of the "explanatory model"—asking questions that allow the patient to share what his/her illness means in terms meaningful to that person. They enumerate six other skills that would prove useful in providing better patient care to all patients.

The article also discusses "buy-in" as critical to the advancement of cultural competence in the health care setting. This can be seen when the clinician truly understands the impact of cultural competence and the significance of its connection to quality health care. Another important principle discussed is the use of "quick facts." That the medical encounter/clinic visit has time constraints is no secret. The authors suggest a framework that helps us obtain useful clinical information about a patient from a sociocultural perspective that will assist in coming up with a differential diagnosis or appropriate intervention.

In the second half of this commentary, Betancourt and Green discuss a key framework for evaluating cultural competence and linking it to health care outcomes. I will highlight some that are relevant to WIPHL. Interventions that are successful in changing performance and health care outcomes, they believe, are those using practice-enabling strategies (e.g. office facilitators or methods of patient education) or reinforcing methods (e.g. feedback or reminders). Given this approach based on the research literature, educational intervention would have the best impact on health care outcomes if it is multifaceted and includes some suggested strategies. A few of the strategies are as follows:

1. Focus on a particular condition (e.g. alcohol misuse, depression)

2. Target a specific population (e.g. cultural implications of alcohol/drug misuse)

3. Teach specific skills (e.g. use of a specific screening tool for non-adherence)

4. Develop practice-enabling strategies (e.g. prompts in the electronic record/protocol)

5. Create a patient component (e.g. patient-based intervention tools)

These strategies are a partial list of those put forth by the authors. I would encourage a review and discussion of the entire article to elicit more insight regarding the importance of cultural competence as a building block of clinical care and a skill set that is central to professionalism and quality.

Month End Data

Year 4 Month 9
May 14 – June 15, 2010

Clinics	*Eligible for BS**	*Completed BS*	*% BS Completed*	*Positive BS*	*% BS Positive*	*Completed FS*	*% FS Completed*
Aurora Sinai Family Care Center (0.9 FTE)	140	118	84.3%	42	35.6%	60	142.9%
Aurora Sinai Women's Health Center (0.9 FTE)	170	143	84.1%	46	32.2%	60	130.4%
Aurora Walker's Point (0.9 FTE)	209	208	99.5%	58	27.9%	54	93.1%
Beloit Area Community Health Center	194	188	96.9%	73	38.8%	64	87.7%
Columbia St. Mary's	200	187	93.5%	72	38.5%	62	86.1%
Dean East	227	214	94.3%	82	38.3%	69	84.1%
Family Health/ La Clinica (0.5 FTE)	115	110	95.7%	30	27.3%	13	43.3%
Gundersen Lutheran Family Medicine	239	232	97.1%	88	37.9%	53	60.2%
Gundersen Lutheran Trauma Center	81	n/a	n/a	n/a	n/a	78	96.3%
Marshfield - Minocqua Center (0.9 FTE)	202	183	90.6%	36	19.7%	20	55.6%
Menominee Tribal Clinic	255	204	80.0%	63	30.9%	60	95.2%
Milwaukee Health Services, Inc. (0.3 FTE)	13	3	23.1%	2	66.7%	2	100.0%
Northeast Family Medical Center	225	193	85.8%	71	36.8%	63	88.7%
Scenic Bluffs Community Health Center (0.2 FTE)	16	16	100.0%	2	12.5%	1	50.0%
St. Joseph's Community Health Services - Adolescents	12	10	83.3%	2	20.0%	1	50.0%
St. Joseph's Community Health Services - Adults	132	132	100.0%	28	21.2%	16	57.1%
Upland Hills Health	157	142	90.4%	27	19.0%	17	63.0%
Waukesha Family Practice Center	261	247	94.6%	72	29.1%	60	83.3%
Grand Totals	**2,848**	**2,530**	**88.8%**	**794**	**31.4%**	**753**	**94.8%**

*Eligibility varies by clinic

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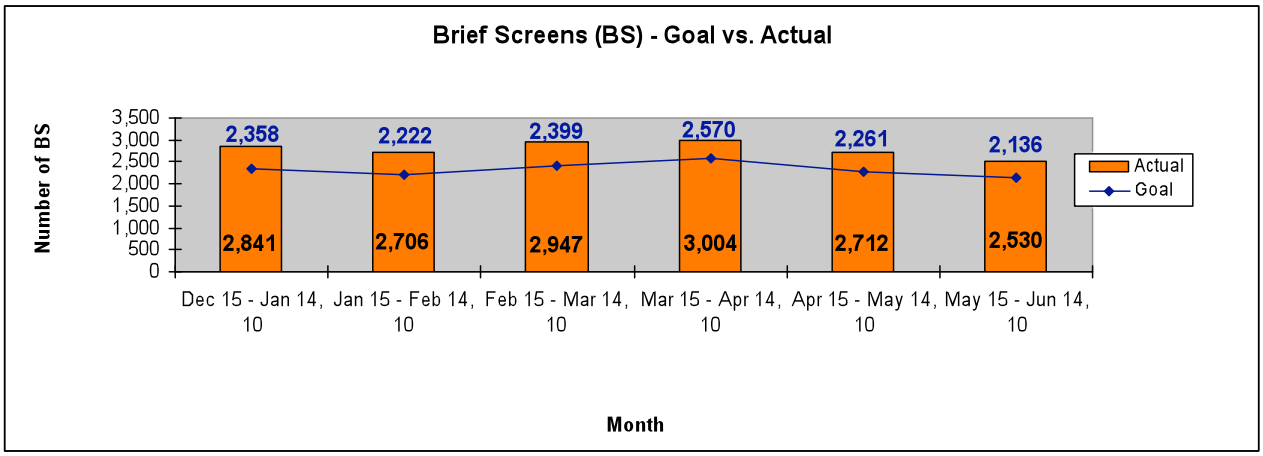
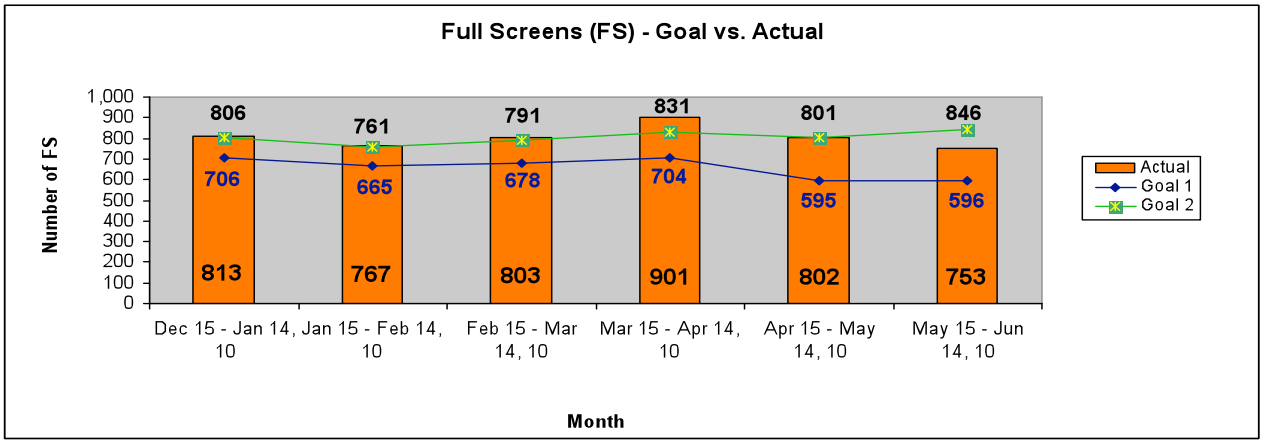
Six-Month Wrap-Up



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



Actual: Number of full screens completed
Goal 1: Year 4 (Sept 15, 2009 - Sept 14, 2010) - Full screen 75% of patients who brief screen positive
Goal 2: Year 4 (Sept 15, 2009 - Sept. 14, 2010) - Number varies by site based on start date

Access to SBIRT Update

Reflections on Smoke-Free Wisconsin

By Mia Croyle

Next month Wisconsin will be smoke-free.

On July 5, the ban on smoking in all Wisconsin workplaces-including restaurants and bars-will go into effect. It has been hard to imagine that this day would ever come. Even as I write this, I can barely believe it. And even more amazingly, there will now be kids who grow up never knowing any other way.

We can see evidence of this culture change already. Some folks at the WIPHL Coordinating Center can recall smoking lounges in their high schools. For others of us, that idea is unfathomable. I was just on a brand new airplane and they didn't even have an illuminated "no smoking" sign. It is no longer necessary to have one that can be turned on or off depending on the length of the flight—the permanent "no smoking" sign on the back of each seat serves in all situations.

I'm not saying that the fight is over and the threat posed by tobacco use to the health of Wisconsinites is over. There is still a lot of work to be done to help current smokers quit and stay quit. And we also have to figure out a way to prevent kids from ever starting. What I am saying is that this is a huge victory and those of us who are concerned with wellness in the state of Wisconsin should take time to celebrate.

So often it feels like we are fighting an uphill battle. The drinking culture in Wisconsin seems so entrenched, the systems of providing treatment to those who need it seem so woefully underfunded and disorganized. The health care system and the health care funding systems have treated problematic substance use as a "specialty" issue for so long it's a struggle to get screening and intervention services to take hold in general health care settings. Sometimes it seems it will take a seismic paradigm shift to effect the changes we'd like to see.

A seismic paradigm shift: that's what a Smoke Free Wisconsin represents.

The Last Word

From a clinic in southcentral Wisconsin

A patient in his early 40s was well known in our clinic because he had some pretty serious health problems. Providers had really gone out of their way to try and help him with patient assistance programs and that type of thing—however, his follow-through was always very inconsistent.

One of the times he was in the clinic I met with him, went through the protocols, and it turns out that part of the reason for that inconsistency was an addiction to crack cocaine. With WIPHL's assistance, he was able to successfully complete treatment.

A year later he came into the clinic for follow-up. There'd been some ups and downs in that year—he had lost his job—but he had remained clean. But he described some other problems he was experiencing—vision changes, increased urination. The provider did some tests and it turned out he had developed diabetes. Where the success of WIPHL comes in is that because he had maintained sobriety, he was able to effectively follow up—get the blood work done, take the medication, follow the recommendations of the providers. He was able to get his diabetes under control, which is something that previously, with his other conditions, he had struggled with.

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