The WIPHL Word

Wisconsin Initiative to Promote Healthy Lifestyles

May 2010 www.wiphl.org Volume 4 No. 5

The Director's Desk

Integrating Mental Health and Substance Abuse Care in General Medical Settings

By Richard L. Brown, MD, MPH
Clinical Director

At WIPHL, most of our efforts focus on integrating SBIRT services into health care settings. Last month I had the pleasure of attending a meeting in Washington where broader views of medical, mental health, and substance abuse services were under discussion.

The meeting was sponsored by TRI, a research and policy group from Philadelphia which once was part of the University of Pennsylvania. SAMHSA, WIPHL's funding source, provided financing for TRI to conduct this meeting. TRI brought together many policy leaders and innovators to discuss ways to better integrate mental health, alcohol, and drug services into mainstream health care. I was invited to make a presentation about WIPHL, especially because of our efforts toward building sustainability in SBIRT service delivery after our grant funding expires next year.

There were many inspiring presentations on work being done across the nation. Our counterparts at Colorado's SBIRT program have excelled especially at integrating SBIRT services into HIV clinics. Federally qualified health centers in Bangor, Maine, Asheville, North Carolina, and in several counties in California have innovatively co-located mental health, alcohol, and drug services in the same settings. A community-based managed care program for the elderly in Massachusetts targets high health care utilizers with mental health, alcohol, and drug screening and intervention services. A Kaiser Permanente program improves birth outcomes by providing SBIRT as a standard part of prenatal care. Groups in Massachusetts and Baltimore have substantially expanded access to buprenorphine and demonstrated cost savings.

The conclusion was that integrating these services is the way of the future. If we truly value better health outcomes and lower costs, we can no longer maintain separate, uncoordinated systems of care.

The conclusion was that integrating these services is the way of the future. Advantages are reducing stigma, enhancing effectiveness of referrals, and supporting early identification and intervention. If we truly value better health outcomes and lower costs, we can no longer maintain separate, uncoordinated systems of care.

Although WIPHL's primary emphasis remains screening and intervention, we've realized the need to better serve in our primary care settings dependent patients who cannot or will not received specialized addiction treatment. Please see page 3 for Mia Croyle's article on our new pharmacotherapy initiative. Thanks to Beloit Area Community Health Center, Family Health/La Clinic and UW Northeast Family Medical Center for stepping forward as innovators for this program. And thanks to all WIPHL partners and supporters for your great work bringing SBIRT services to many Wisconsin patients. Your excellence in innovation is now even more widely appreciated in Washington and beyond.

Project Manager Update

The "Big Rocks" and the Road Ahead

By Candace Peterson, PhD

As WIPHL approaches Year 5 of SBIRT delivery, I've got big rocks on my mind. Some of you may remember reading my reference to "putting in the big rocks first" in WIPHL's December '09 newsletter. I used a short story to illustrate an important principle about priorities, focus, and productivity in the workplace.

In it, I quoted noted author Stephen Covey as saying, "If you don't put the big rocks in first, you'll never get them in at all." The article emphasized the wisdom and importance of identifying what is most important for us, and then make our decisions based on those very important criteria. For WIPHL, in a recent strategic planning process we identified those "big rocks" for the SBIRT project—WIPHL's priorities. Here, again, are WIPHL's "big rocks":

Rock I: Consistently deliver efficient, high quality SBIRT services

Rock 2: Maintain WIPHL infrastructure and meet grant requirements

Rock 3: Make behavioral prevention services routine in Wisconsin health care settings (growth and sustainability)

WIPHL wants to continue to bring these priorities to life in our day-to-day decisions and operations. As the federally funded SBIRT project enters its fifth and final year, we are particularly focused on Rock #3: growth and sustainability. We are committed to building capacity, demand, and support for widespread SBIRT implementation. Our ultimate goals are that alcohol and drug SBIRT services will continue to be delivered in our present sites and will be offered at increasing numbers of other sites. Here are several "Rock 3" efforts taking place in the next few months:

1. We've asked each of our WIPHL-funded clinical sites to think seriously about sustainability of SBIRT service delivery after grant funding ends. We've distributed a worksheet to each of our current sites to be used in assessing commitment, barriers, and possible solutions, and to generate ideas for successfully implementing SBIRT after grant funding ends. We will continue to work with our current SBIRT sites to build capacity for sustainability.

2. WIPHL hosted a Dane County Healthcare Leaders Meeting on May 20 featuring representatives from the Madison mayor's and Dane County executive's offices as well as Madison/Dane County public health. They, along with WIPHL clinical director Dr. Rich Brown, addressed an audience of Dane County healthcare providers and other stakeholders about universal behavioral screening and intervention in healthcare and what healthcare providers, payers, and purchasers can do to ensure that this service is implemented. WIPHL hopes to hold similar meetings in other counties around the state.

3. We continue to work with policymakers and health care payers and purchasers to build demand and support for SBIRT and remove barriers to implementation (such as SBIRT services being subject to co-pays and deductibles). WIPHL will hold four half-day regional conferences in August and early September in Madison, Milwaukee, Wausau, and the Fox Valley. The objective of these conferences, which will be coordinated and co-hosted by the Wisconsin Safety Council (an affiliate of Wisconsin Manufacturers and Commerce), is to increase understanding of and support for SBIRT and to promote demand for SBIRT services, in particular with businesses and key healthcare funders. We'll introduce SBIRT to this audience as a comprehensive, integrated, public health approach to the delivery of screening, early intervention, and treatment services for behavioral health. And we'll help them understand that universal behavioral screening and intervention lead not only to healthier behaviors but also to lower healthcare costs and higher productivity.

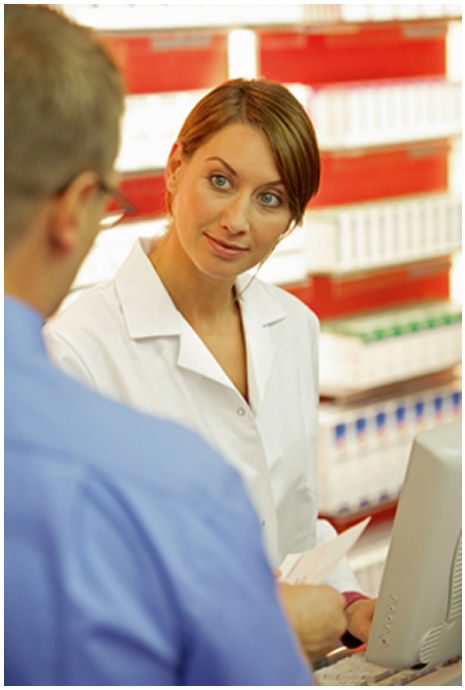
Those are a lot of rocks—and those of us who work in healthcare may appreciate an analogy between Covey's rocks and the heavy lifting it takes to improve our system. But improve it we will. Our final year of federal funding won't see any slacking off, but rather a redoubling of our efforts.

Access to SBIRT Update

Improving Access to Pharmacotherapy

By Mia Croyle

WIPHL has established as a project-wide priority improving our care of patients in the likely dependent category of use, particularly patients who are likely dependent on alcohol. A high prevalence of our patients fall into this category. Dependence often carries severe health and social consequences for patients, family members, and others in our communities. Statewide, we have been able to enroll in treatment fewer than 10% of patients whose full screens suggest likely dependence. This is no worse than other SBIRT projects, but we've been working on developing other ways of helping these patients.



To that end, we have undertaken an initiative to reduce barriers to clinical sites and providers treating their dependent patients with pharmacotherapeutic agents (i.e., prescription medications). Research has shown that pharmacotherapy is effective for many patients. Pharmacotherapy administered in WIPHL general medical settings could be augmented with ongoing support from WIPHL health educators. In this way, patients would be able to receive care for their dependence in the general medical setting where they already go for other care. For some patients, this care might be further augmented by services in a specialty addiction treatment setting.

Last year, WIPHL partnered with an excellent consultant, Dr. Randy Brown, a UW family physician and certified addiction medicine specialist. Brown conducted two introductory webinar sessions last August and also traveled to interested sites to conduct educational programs for providers on treating dependent patients with prescription medications. (You can find instructions for viewing archived webinars at www.wiphl.com under Events/Pharmacotherapy with Dr. Randy Brown.)

We are pleased to announce that, after much planning, WIPHL will partner with UW Health pharmacies to pilot a program to provide funding support for patients interested in and appropriate for pharmacotherapy. The pilot program started May 17 at three of our clinics. These clinics participated in the educational programs with Brown last year and expressed a willingness to work with us to figure out innovative methods of reducing barriers to treating dependent patients with pharmacotherapy in the general health care setting.

An important part of this program involves collaboration between providers and health educators in managing pharmacotherapy patients. Health educators will be working with patients to develop behavior change plans, assisting providers with assessing patients' progress at follow-up visits, and working with patients to modify change plans as needed.

We hope that this model will maximize outcomes and health care provider efficiency while improving our ability to respond to patients with likely dependent use of alcohol and other drugs. If the pilot proves to be a successful model, we will be looking to expand it to other WIPHL sites.

Cultural Competence Update

Why Engage in Cultural Competence?

By Harold Gates

The question being pondered this month is "Why is There a Compelling Need for Cultural Competence?" According to the National Center for Cultural Competence housed at Georgetown University, we have to consider cultural competence in organizational policy/service delivery for the following reasons:

1. To respond to current and projected demographic changes in the United States.

The make-up of the American population is changing as a result of immigration patterns and significant increases among racially, ethnically, culturally and linguistically diverse populations already living here. Health care organizations and programs, and federal, state and local governments must implement systematic change in order to meet the health needs of this diverse population.

2. To eliminate long-standing disparities in the health status of people of diverse racial, ethnic and cultural backgrounds.

Despite recent progress in overall national health, there are continuing disparities in the incidence of illness and death among African Americans, Latino/Hispanic Americans, Native Americans, Asian Americans, Alaskan Natives, and Pacific Islanders as compared with the U.S. population as a whole.

3. To improve the quality of services and health outcomes.

The delivery of high quality primary health care that is accessible, effective, and cost efficient requires health care practitioners to have a deeper understanding of the socio-cultural background of patients, their families, and the environments in which they live. Culturally competent primary health services facilitate clinical encounters with more favorable outcomes, enhance the potential for a more rewarding interpersonal experience, and increase the satisfaction of the individual receiving health cares services.

In making a diagnosis, health care providers must understand the beliefs that shape a person's approach to health and illness. Knowledge of customs and healing traditions are indispensible to the design of treatment and interventions. Health care services must be received and accepted to be successful.

Increasingly, cultural knowledge and understanding are important to staff responsible for quality assurance programs. In addition, those who design evaluation methodologies for continual program improvement must address hard questions about the relevance of health care interventions. Cultural competence will have to be soundly linked to the definition of specific health outcomes and to an ongoing system of accountability that is committed to reducing the current health disparities among racial, ethnic and cultural populations.

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Cultural Competence, from previous page

4. To meet legislative, regulatory and accreditation mandates.

As both the enforcer of civil rights laws and a major purchaser of health care services, the federal government has a pivotal role in ensuring culturally competent health care services. State and federal agencies increasingly rely on private accreditation entities to set standards and monitor compliance with these standards. Both the Joint Commission on Accreditation of Healthcare Organizations, now known as the Joint Commission, which accredits hospitals and other health care institutions, and the National Committee for Quality Assurance (NCQA), which accredits managed care organizations and behavioral health managed care organizations, support standards that require cultural and linguistic competence in health care.

5. To gain a competitive edge in the marketplace.

Issues of concern in the current health care environment (remember health care reform) include the marketing of health services and the cost-effectiveness of health care delivery. The potential for improved services lies in state managed-care contracts that can increase retention and access to care, expand recruitment and increase the satisfaction of individuals seeking health care services. To reach these outcomes, managed care plans must incorporate culturally competent policies, structures and practices to provide services for people from diverse ethnic, racial, cultural and linguistic backgrounds.

6. To decrease the likelihood of liability/malpractice claims.

Lack of awareness about cultural differences may result in liability in several ways. For example, providers may discover that they are liable for damages as a result of treatment in the absence of informed consent. Also, health care organizations and programs face claims that their failure to understand health beliefs, practices, and behavior on the part of providers or patients breaches professional standards of care (i.e., negligence). The ability to communicate well with patients has been shown to be effective in reducing the likelihood of malpractice claims. Effective communication between providers and patients may be even more challenging when there are cultural and linguistic barriers. Health care organizations and programs must address linguistic competence—ensuring accurate communication of information in languages other than English.

It is my hope that this information gives you pause to think about what you are doing to provide culturally competent SBIRT services in your clinic setting. Technical assistance is available to help your many facets of service delivery. On the next page, please see the form that can be sent to me. I encourage you to review this article and my WIPHL Word articles over the past few months to assess where your organization is now. I can be reached at Harold.Gates@fammed.wisc.edu or (608) 265-4032.

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Wisconsin Initiative to Promote Healthy Lifestyles (WIPHL)
Cultural Competence Technical Request Form

This form is devised as way for our clinics and partners to request the kind of technical assistance that helps them deliver quality, culturally competent SBIRT services to their patients. Often request fall into one of five categories. They include:

1. Finding a community leader or expert on a topic related to cultural competence
2. Identifying a community resource
3. Facilitating a technical assistance meeting with clinic team about cultural competence
4. Design, deliver, and collaborate on a cultural competence workshop or training.
5. Provide assistance in identifying culturally competent written materials

Please identify the category of technical assistance you are seeking by circling one of the categories above and provide a description of your technical assistance need by addressing the following questions:

1) What is our clinic's need regarding culturally competent services at this time?

_____
_____
_____
_____

2) How will this technical assistance relate to providing the best possible WIPHL services as an organization?

_____
_____
_____
_____

3) What immediate outcomes are being sought?

_____
_____
_____
_____
_____

4) What final outcomes are being sought?

_____
_____
_____
_____
_____

Timeframe for technical assistance_____
Date of request_____

Please submit request forms to Harold Gates at Harold.gates@fammed.wisc.edu

Month End Data

Year 4 Month 8
April 14 – May 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)	152	143	94.1%	53	37.1%	56	105.7%
Aurora Sinai Women's Health Center (0.9 FTE)	175	152	86.9%	48	31.6%	63	131.3%
Aurora Walker's Point (0.9 FTE)	224	224	100.0%	64	28.6%	60	93.8%
Beloit Area Community Health Center	302	279	92.4%	80	28.7%	81	101.3%
Columbia St. Mary's	202	202	100.0%	69	34.2%	65	94.2%
Dean East	250	241	96.4%	85	35.3%	86	101.2%
Family Health/ La Clinica (0.5 FTE)	194	190	97.9%	44	23.2%	12	27.3%
Gundersen Lutheran Family Medicine	315	297	94.3%	114	38.4%	66	57.9%
Gundersen Lutheran Trauma Center	70	n/a	n/a	n/a	n/a	69	98.6%
Marshfield - Minocqua Center (0.9 FTE)	198	183	92.4%	51	27.9%	43	84.3%
Menominee Tribal Clinic	271	215	79.3%	63	29.3%	62	98.4%
Milwaukee Health Services, Inc. (0.3 FTE)	21	5	23.8%	4	80.0%	3	75.0%
Northeast Family Medical Center	195	146	74.9%	56	38.4%	53	94.6%
Scenic Bluffs Community Health Center (0.2 FTE)	17	17	100.0%	2	11.8%	0	0.0%
St. Joseph's Community Health Services - Adolescents	155	155	100.0%	34	21.9%	24	70.6%
St. Joseph's Community Health Services - Adults	14	14	100.0%	4	28.6%	1	0.0%
Upland Hills Health	181	170	93.9%	50	29.4%	28	56.0%
Waukesha Family Practice Center	79	79	100.0%	35	44.3%	30	85.7%
Grand Totals	**3,015**	**2,712**	**90.0%**	**856**	**31.6%**	**802**	**93.7%**

*Eligibility varies by clinic

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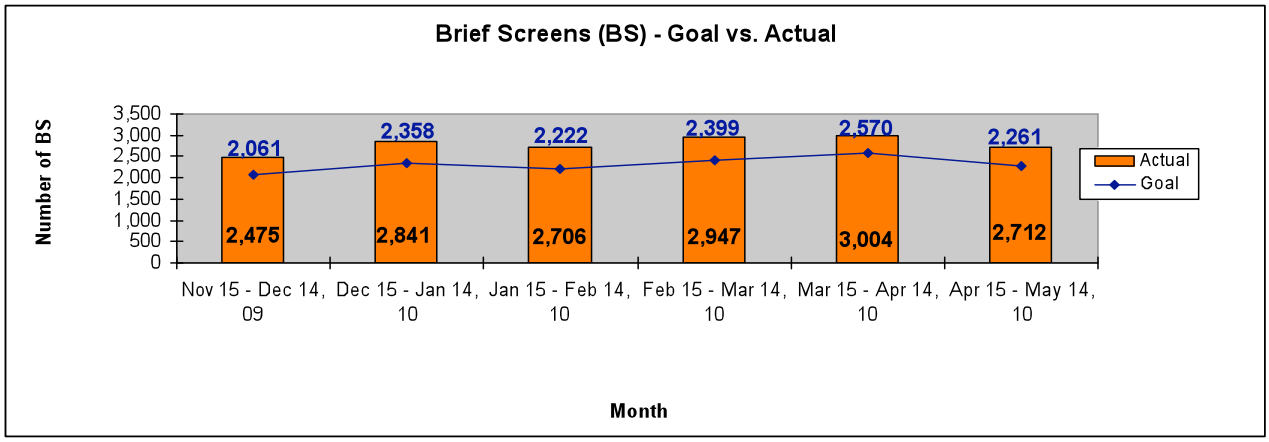
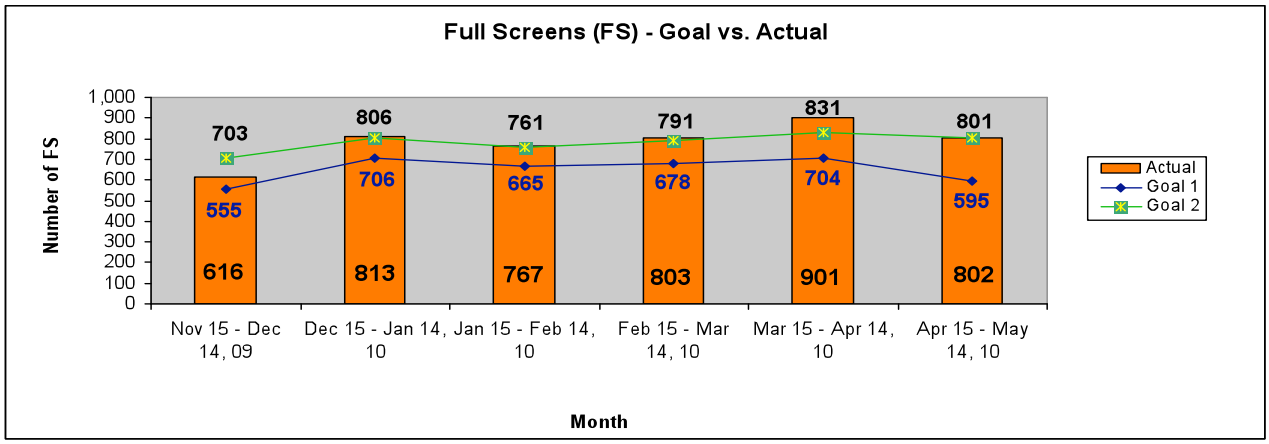
Six-Month Wrap-Up

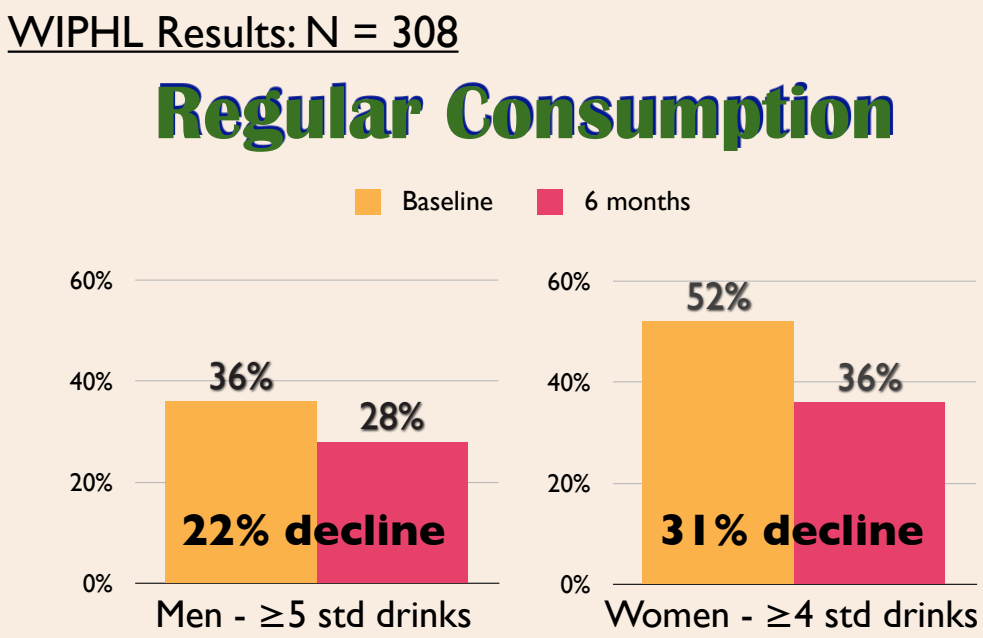


Actual: Number of brief screens completed
Goal: Brief screen 75% of eligible patients



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

Did You Know? *WIPHL patients at six-month follow-up showed enormous declines in regular alcohol consumption*



The Last Word

From a health educator in southeastern Wisconsin

I first began seeing this particular patient (a 46-year-old woman) in spring 2008. She was drinking up to 12 drinks a day and was very embarrassed by it. Because of that, she frequently expressed her gratitude that the WIPHL approach is non-judgmental.

I continued to pop in to see her every once in a while over the past two years hoping she would be ready for change. Each time I spoke with her I recognized a difference in her stage of change, and we had a number of successful MI sessions. There was a point at which she considered Naltrexone treatment but backed out at the last minute.

I screened her for the third time a couple of weeks ago and could not believe what greeted me in the exam room. She looked fabulous! Her drawn, gray, overly thin look was gone. She was smiling, pink-cheeked and boisterous, and couldn't wait to tell me about all the changes she has made. Our conversations over the years finally had come to fruition.

She hasn't had a drink in seven months and feels great. She looks 10 years younger. Her provider and I have been concerned about her for a long time, and we are both so happy about this.

Before I left the room, in referring to my business cards, she said, "I keep you on my fridge, in my purse, in my car, and in my drawer." I think that's interesting because she never called me in between sessions. But clearly they had an effect!

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.