The WIPHL Word
Wisconsin Initiative to Promote Healthy Lifestyles
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Director's Desk

Billing for SBIRT – More Complicated Than You'd Think

By Richard L. Brown, MD, MPH

Most of us are drawn to WIPHL because providing SBIRT services improves health and well-being for individuals, families, and communities. You might think that this alone should be enough to assure that we can continue delivering services from now on, but in our capitalistic health care delivery environment, a viable business model will be needed. For participating clinics, this business model must provide financial support for health educators. Accordingly, WIPHL is moving toward implementing billing on a trial basis at two clinics—the Menominee Tribal Clinic and the UW Health-Northeast Family Medical Clinic.

You might think that that new Medicare, Medicaid, and commercial billing codes would make this easy. Unfortunately, that's not the case. The rules around the billing codes are quite arcane. We've tried to capture what we know about the rules in a web-based document. See the "What's New at WIPHL" box at www.wiphl.org for a quick link.

For now, here's a brief summary for Wisconsin primary care clinics:

• Medicare is the most certain plan to reimburse at this point. Fifteen to 30 minutes of screening and intervention services will garner $29.42. For more than 30 minutes, Medicare will pay $57.69. There are two caveats: (1) Services must be provided in the context of a visit for an illness or injury, not a visit where only preventive services are provided; and (2) Medicare can be billed only if other payers are being billed for the same services.

• Since new commercial billing codes were made available nationally, 86 of 150 surveyed commercial insurance companies indicated willingness to pay on them. Whether Wisconsin companies will pay is as yet unknown. Therefore, clinics are understandably reluctant to bill for SBIRT services when denied claims may result. To help jump-start billing to commercial insurers, WIPHL will soon be contacting them, providing information on the benefits of SBIRT services, and asking for a commitment to pay for them. We'll keep you posted.

• Wisconsin Medicaid (BadgerCare Plus) has not implemented the new national SBIRT codes. It has implemented new codes (H0002 and H0004) for SBIRT services for pregnant women only.

The good news is that while we wait for implementation or clarification of the new SBIRT billing codes, clinics can start to bill for services using standard E & M codes. When a provider and health educator see the patient on the same day, the provider's coding can account for the history that the health educator gathered and any increased complexity in clinical decisonmaking. When the health educator is the sole provider, a supervising provider can submit a bill for a nursing visit.

Thanks to the Menominee and Northeast clinics—including their providers, health educators, and staff—we'll soon be learning much more about billing, and we'll continue to update our web-based document as we go. In the mean time, we're fortunate to have a grant to fund SBIRT service delivery and continue making important differences for patients, families, and communities.

Our New Project Manager

We give a warm welcome to Candace Peterson, WIPHL's new project manager. Candace brings a wealth of experience and enthusiasm to our project.

"I am passionate about helping people develop healthy lifestyles and believe WIPHL is a powerful tool for changing lives," she says.

Candace holds a Ph.D. in adult education from the University of Wisconsin–Madison. She has worked in the substance abuse field since 1990, primarily in prevention, screening, and early intervention. She served as manager of substance abuse services for Dane County and was a senior program manager and principal investigator at the Pacific Institute for Research and Evaluation, one of the nation's leading independent nonprofit health research and evaluation organizations. In addition, she has worked on numerous projects as an independent consultant, trainer, and facilitator.

"My experience in substance abuse prevention, public policy, systems change, evaluation, and collaboration in project management and implementation will contribute to WIPHL efforts to build partnerships for health and to develop SBIRT services statewide," she notes.

Candace sets high goals for herself outside of work, too. She is a triathlete and is teaching herself to play piano. She also built her own house, working on it with her partner evenings and weekends over the course of three years. Located in the countryside a few miles outside of Sauk City, the grounds allow her plenty of room for gardening and playing with her dogs, a black lab named Hannah and a golden lab puppy named Keeper.

We all look forward to getting to know Candace better over the coming months. You can reach her at Candace.Peterson@fammed.wisc.edu, tel. (608) 263-3781.

WIPHL, AWARE, and *The New York Times*

Yes, that was WIPHL you may have seen described—though not by name—in the Sunday, November 16 edition of *The New York Times*. The newspaper paraphrases Robert N. Golden, M.D., dean of the University of Wisconsin School of Medicine and Public Health, in saying that "state agencies would use a $12.6 million federal grant to step up screening, intervention and referral services at 20 locations around Wisconsin."

That's us, but it is understandable that Golden and *The New York Times* did not name WIPHL. The occasion of Golden's remarks was to announce another acronym—AWARE—that could have a profound effect on both our program and risky drinking in Wisconsin. AWARE stands for All-Wisconsin Alcohol Risk Education, a first-of-its-kind collaborative coalition of health officials and civic leaders that has been formed to combat the many problems caused by excessive drinking. The group hopes new legislation will fight drunken driving, compel insurers to cover injuries caused by drunken driving, and decrease underage drinking. The group also supports implementing screening, brief intervention, and referral-to-treatment via WIPHL. Under the umbrella of UW Health, coalition leaders are UW Hospital and Clinics, the UW School of Medicine and Public Health, and the University of Wisconsin Medical Foundation.

A coalition on this grand scale will help WIPHL's visibility and could help a great deal in our efforts to make SBIRT services a permanent, universally accessible component of health care in Wisconsin. We will keep you posted on further developments. In the meantime, you can learn more about AWARE at www.uwhealth.org/aware. To read the *New York Times* article, go to our website homepage under "Did You Know?" for an easy link.

Cultural Competence Update

New Dialogue on Cultural Competence

By Harold Gates

The past few weeks have seen a flurry of activity on the national and local levels. It is amazing that Senator Barack Obama has now become President-elect Barack Obama. This is one of those proverbial dreams come true. It is a defining moment in American history and one that moves us in the direction envisioned by Dr. Martin Luther King, Jr. in his "I Have a Dream" speech back in 1963. We have voted a person into office who symbolizes that an African American can be "judged by the content of his character, not the color of his skin." This is major because of the times in which we live as well as the challenges that we face as a nation. President-elect Obama will face many challenges as he takes office, but there is a spirit of change and unity that we have not seen since the '60s. It is also prompting us to discuss what this country is capable of in its finest hour and have higher-level conversations not only about race but other dimensions of diversity as well. We will also be looking at the possibility of a "New New Deal" or ways to tackle such monumental problems as the economy, health care reform, energy reform, and the war in Iraq. It will be very interesting to follow this story over the next few weeks until the inauguration and beyond.

His dream has come closer: The election of our first African American president brings hope for more meaningful discussion about the dimensions of diversity.

On the WIPHL front, we have just brought on Candace Peterson, our new project manager, who brings a wealth of experience in AODA and cultural competence to the position. It will be exciting to have her involved in our cultural competence efforts and our work overall as we grow in accordance with our other major principles of evidence-based practice and quality improvement.

In other news, the Cultural Competency Committee had its most recent quarterly meeting on October 17. One of the highlights was a review of our 2008/2009 work plan. In the area of service delivery, we have completed training for health educators relating to white males, older adults, and the Language Line. These were populations and/or topics that HEs wanted to learn more about in order to better serve their clinic patients. The area of staff/team development has also seen progress on the topic of working with patients that might be coming from the corrections/criminal justice population. We also had some excellent training at our WIPHL biannual statewide meeting that addressed cultural competence from a "critical thinking" perspective, with an emphasis on African American patients. We will continue to look at topics still to be covered in the areas of organizational environment and community relationships. Upcoming health educator teleconferences will address prescription drug abuse and the needs of the LGBQTA community.

Resources and Learning Opportunities

Here's an update on websites that are useful as resources and learning opportunities:

RAC (Rural Assistance Center), www.raconline.org/info_guides/culture/, has a wealth of information relating to cultural competence and limited English proficiency. The site contains: FAQs, tools, funding, documents, organizations, terms and acronyms, contacts, bibliographies, and news relevant to serving our patients based on national resources/websites. I would encourage you to review them and see what might be useful for your local patient population.

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HBO (Home Box Office) has produced *Addiction,* a 90-minute documentary on alcohol and drug addiction that is relevant to our project. It contains the following segments: addiction as a brain disease, adolescent treatment and how it differs from adult, addicts and co-occurring conditions, available medical treatments, and evidence-based behavioral therapies. There is an accompanying booklet and website at www.hbo.com. This documentary is produced in partnership with the Robert Wood Johnson Foundation, the National Institute on Drug Abuse (NIDA), and the National Institute on Alcohol Abuse and Alcoholism (NIAAA).

Parents (The Anti-Drug), sponsored by The National Youth Anti-Drug Media Campaign. This website might prove useful to parents of our adolescent patients. They can take a drug knowledge quiz online at www.theantidrug.com/advice/parenting-drug-knowledge-quiz.asp?id=banner.

UW Health, as discussed on page 2, has formed a coalition, All-Wisconsin Alcohol Risk Education (AWARE), to improve the health and safety of Wisconsin residents in the fight against alcohol abuse. The campaign and accompanying website can be found at www.uwhealth.org/aware.

I encourage you to review all of the above-mentioned resources and websites as they may prove useful for our WIPHL clinics and patient populations. As always, if you need technical assistance or want to discuss issues related to cultural competence, please do not hesitate to call (608) 265-4032 or e-mail me at Harold.Gates@fammed.wisc.edu.

Treatment and SBIRT Access Update

Coverage Parity, SBIRT for Teens

By Mia Croyle

One of the roles of the treatment liaison is to help patients who are covered under private insurance policies navigate and fully utilize their insurance benefits when seeking specialty addition treatment services. Employer-provided health plans have for years routinely set stricter treatment limits and imposed higher out-of-pocket costs on mental health care than care for any other illness. The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, enacted on October 3, is intended to end health insurance benefit inequity between mental health/substance use disorders and medical/surgical benefits for group health plans with more than 50 employees. The law is projected to provide parity protection to 113 million people across the country, including 82 million individuals enrolled in self-funded plans. For most plans, the law takes effect on January 1, 2010. This is an exciting piece of legislation that hopefully will increase people's ability to access and afford the appropriate addiction treatment services. For more information on this legislation, see the fact sheet offered on the website for Mental Health America at www.mentalhealthamerica.net.

WIPHL treatment numbers for Oct. 15 to Nov. 15:

14 referrals to treatment, bringing our project total to 173

7 patients entered treatment, bringing our project total to 64

Expansion of SBIRT Services to Adolescents

We have made great progress on expanding our program's SBIRT services to adolescents! We have developed a pilot version of our intervention protocols and are working with several clinics to prepare for delivering services. On September 29–30 and October 1, we trained our health educators in adolescent development, the impacts of substance use on adolescents, and the use of our adolescent protocols. Currently we have at least seven clinics that are preparing to begin implementing SBIRT services for adolescents. Interested clinics can find the clinic guide and checklist of adolescent services on our website under "About Us/Quality Improvement/Toolbox for Plan-Do-Study-Act."

Health Educator Update

MINTies in New Mexico

By Laura Saunders

Last month I attended the 2008 MINT Forum in Albuquerque. All MINT* members are eligible for attendance at this annual gathering. The meeting alternates being held on opposite sides of the Atlantic to accommodate worldwide members. WIPHL has more MINT affiliates—Laura Saunders, Holly Prince, and Scott Caldwell—than any other program in Wisconsin.

Dr. William Miller, the father of motivational interviewing, lives in Albuquerque, making it the home of MI. This historic spot drew a record number of "MINTies" this year. The Southwest's gorgeous autumn weather tempted us to be outside, but the energizing and thought-provoking sessions kept us in. Many of the messages reinforced the training and coaching that I currently provide, while others provided ideas for change.

Dr. William R. Miller

As always, hearing Bill Miller speak humbly about a movement that is rapidly escalating in popularity is a thrill. Miller reminded us that as practitioners we have to maintain our belief—be it ever so radical—in human potential. We have to recognize the central role of choice and decision, we must understand and accept ambivalence, and, as the newest science around MI tells us, we have to pay very close attention to language, the practitioners, and the clients. The brevity of the MI relationship requires these things, although these concepts can certainly be applied to longer-term counseling relationships.

As if hearing from the father of MI wasn't exciting enough, we were also treated to a talk about mechanisms of change by Carlo DiClemente, father of the transtheoretical model. DiClemente reminded us that the stages of change are arbitrary and are not meant as labels but rather as a heading for the tasks that need to be completed before people can make change—change that lasts. Just one other highlight among many was his reminder that we have to think about how health behaviors become a part of who the person is—"I am a smoker" or "I am a drug abuser"—and what that means when a person is considering a change.

Other sessions, "Booster MI training" and "Exercises to use in teaching health behavior change," provided me with a renewed energy to coach WIPHL HEs toward greater MI proficiency. Altogether it was time well spent in the beautiful Southwest!

* ***Motivational Interviewing Network Trainer***

Month End Data

October 15, 2008–November 14, 2008

Clinic	Eligible for BS*	Completed BS	% BS Completed	Positive BS	% Positive BS	Completed FS	% FS Completed
Wave 1							
Northeast	263	209	79%	79	38%	53	67%
Polk County	93	90	97%	29	32%	24	83%
St. Joseph's	130	121	93%	42	35%	50	119%
Totals	*486*	*420*	*86%*	*150*	*36%*	*127*	*85%*
Wave 2							
Amery	123	111	90%	36	32%	28	78%
FamHlt/LaCl. (0.5 FTE)	113	113	100%	33	29%	26	79%
Menominee	340	233	69%	44	19%	38	86%
Totals	*576*	*457*	*79%*	*113*	*25%*	*92*	*81%*
Wave 3							
Mercy Clinic South	178	151	85%	47	31%	23	49%
Waukesha	319	226	71%	61	27%	43	70%
Totals	*497*	*377*	*76%*	*108*	*29%*	*66*	*61%*
Wave 4							
Minocqua	224	172	77%	52	30%	22	42%
St. Luke's	244	180	74%	41	23%	39	95%
Totals	*468*	*352*	*75%*	*93*	*26%*	*61*	*66%*
Wave 5							
Family Care Center	135	122	90%	47	39%	38	81%
Mayfair (0.5 FTE)	438	346	79%	59	17%	11	19%
Milwaukee Health Services (0.3 FTE)	62	42	68%	18	43%	10	56%
Scenic Bluffs (0.2 FTE)	22	22	100%	8	36%	5	63%
St Croix Tribal Clinic (0.5 FTE)	58	20	34%	6	30%	6	100%
Totals	*715*	*552*	*77%*	*138*	*25%*	*70*	*51%*
Grand Totals	**2,742**	**2,158**	***79%***	**602**	***28%***	**416**	***69%***

*Eligibility varies by clinic

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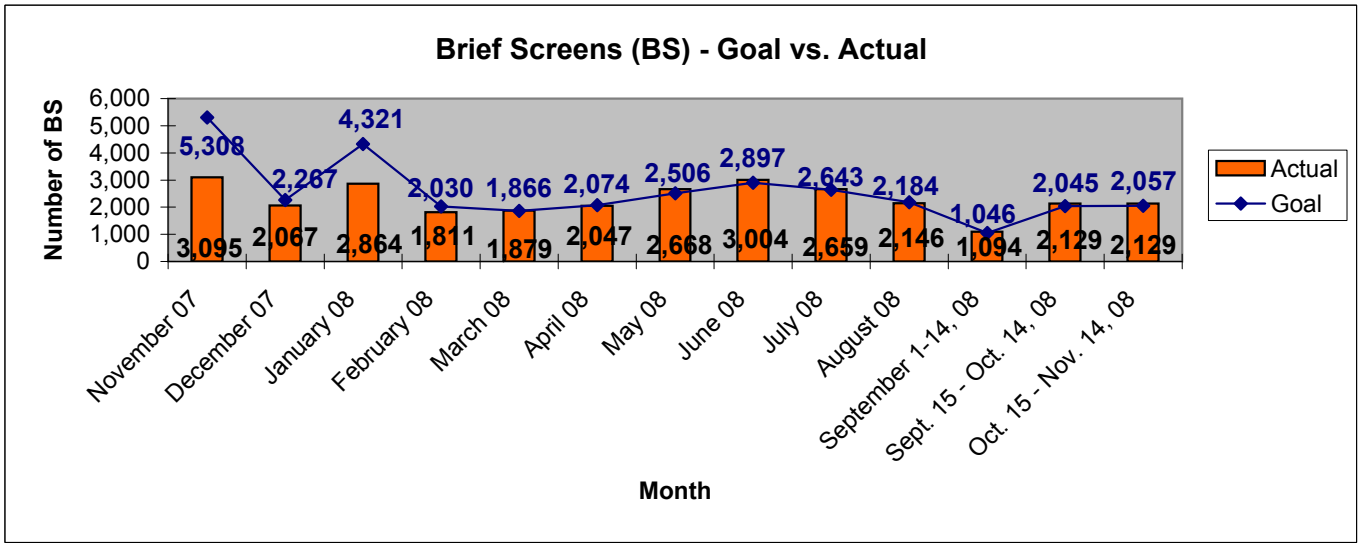
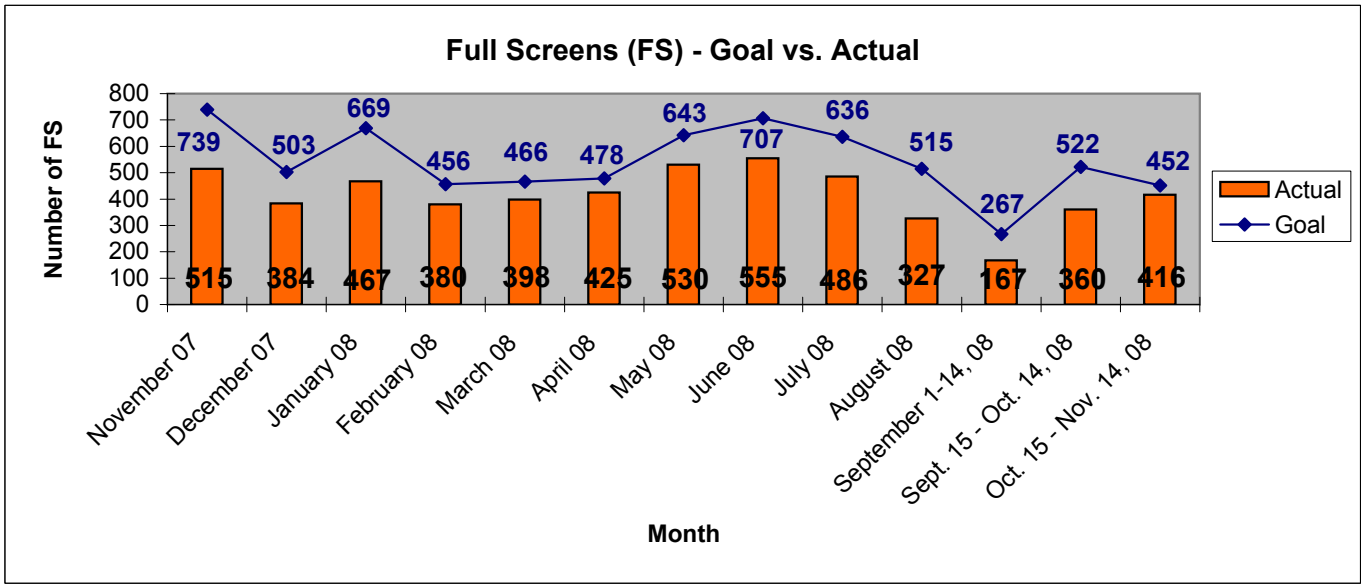
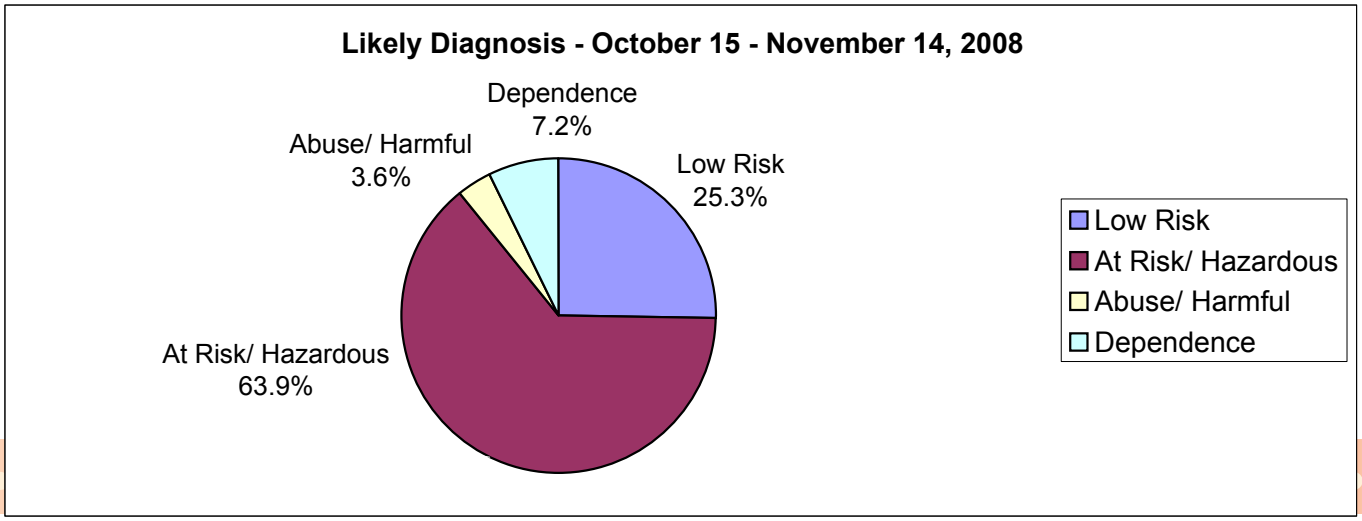
Year to Date Data



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



Actual: Number of full screens completed
Goal: Year 3 (Sept. 15, 2008 - Sept. 14, 2009) - P4P Clinics: Full screen 75% of patients who brief screen positive
Goal: Year 3 Quarter 1 Goal (Sept. 15 - Dec. 14, 2008) - WIPHL Funded: Full Screen 150 patients per clinic (prorated based upon % FTE)



Calendar

November 20
Governor's Policy Subcommittee Meeting, Access for Adolescents, 11 a.m.–12:45 p.m.

November 24
Governor's Policy Subcommittee Meeting, Co-Occurring Conditions, 11 a.m.–1 p.m.

December 8
Governor's Policy Subcommittee Meeting, Promoting Demand for SBIRT Services, 1–2 p.m.

For health educator meetings, please see www.wiphl.org

The Last Word

It takes a village (sometimes)

From a clinic in southeastern Wisconsin

Some patients at WIPHL clinics persist in seeking help with their substance abuse problems despite enormous hurdles.One such story, from a clinic in southeastern Wisconsin, reflects not only the barriers these patients face, but how WIPHL helps patients overcome them.

A patient had no access to a car and was unable to use public transportation on her own due to various mental health problems, some of them stemming in part from years of cocaine and alcohol misuse. The patient's main caretaker, her sister, was unable to accompany her because of physical ailments that prevented her from standing for long periods of time. They had no money for other options. All of these barriers posed a significant logistical problem to the patient in getting to an agency for an AODA assessment, which she needed in order to enter residential treatment.

It took a village to overcome those barriers, and the WIPHL health educator and treatment liaison were a key part of it. They worked with the clinic, the assessment agency, and the patient's health insurance provider to determine that the patient's transportation and treatment would be covered. All of these parties worked together to ensure that the assessment took place, and the patient was able to quickly enter a 60-day treatment program.

"What really feels wonderful is that the patient and her sister really wanted this," says the health educator.

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.