The WIPHL Word

Wisconsin Initiative to Promote Healthy Lifestyles

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The Director's Desk

As the Political Pendulum Swings: SBIRT and Healthcare Reform

Richard Brown, MD, MPH,
WIPHL Clinical Director

Regardless of your political persuasion, there can be no argument that the political pendulum made a substantial swing toward the Republican Party throughout the US earlier this month. There is no more dramatic example than Wisconsin, where the executive and legislative branches of government will move from complete Democratic to complete Republican control.

Across the country and in Wisconsin, just as everyone was becoming accustomed to the uncertainties of healthcare reform, there is a new dimension of uncertainty about how much of healthcare reform, whatever it was going to be, will actually be implemented. So, here's a guide to how SBIRT will likely be affected.

Most commercial healthplans in our state reimburse under special SBIRT codes, and we are currently working hard to secure reimbursement when services are provided by health educators, even when other professionals deliver other services at the same visit. Will SBIRT reimbursement by commercial plans slip backwards under Republican leadership?

No, absolutely not. The aspect of healthcare reform that is most contentious – on which Wisconsin may soon join other states in contesting – involves imposing financial penalties on individuals who do not purchase health insurance. A much less contentious aspect of healthcare reform, which affects WIPHL most, is the requirement that all healthplans reimburse for services with Grade A or B ratings from the US Preventive Services Task Force – including tobacco, alcohol and depression screening and intervention – without out-of-pocket expenditures by patients. New healthplans were required to comply with this requirement as of September 23, 2010. Plans that don't substantially change their benefits are exempt from this requirement. However, several healthplan administrators recently told me that most plans in Wisconsin will implement this change on January 1, 2011.

Commercial health plan reimbursement for SBIRT is likely to continue expanding for at least three reasons. One is that much of the shift is already occurring and may be difficult to reverse. Two, the most likely way that the Republican-controlled House will modify healthcare reform is by not funding it, and mandates that commercial plans reimburse for preventive services do not require funding. The third and most important reason is that the business community – including the National Business Group on Health, Wisconsin Manufacturers and Commerce, and the Wisconsin Safety Council– solidly backs SBIRT, because

continued next page

The Director's Desk

Political Pendulum continued

it is documented to result in a healthier workforce, higher productivity, fewer workplace injuries, improved public safety, and lower healthcare costs.

Wisconsin Medicaid expanded its reimbursement for SBIRT on January 1, 2010, from pregnant women only to all Medicaid recipients. Healthcare reform does not require Medicaid reimbursement for SBIRT until January 1, 2013. Under new Republican leadership, will Wisconsin Medicaid rescind its SBIRT benefit?

I highly doubt it. SBIRT delivered to Medicaid recipients who are employed results in the same workplace benefits for employers. For all Medicaid recipients, taxpayers benefit through averted hospitalizations, emergency department visits and public safety problems. Of course, once key Republican leaders are identified, we'll be sure they come to understand that SBIRT benefits everyone, and we'd be glad for your suggestions and assistance.

So, be assured that recent political changes are highly unlikely to create a drag on SBIRT momentum. In fact, dissemination might even accelerate because of SBIRT's documented cost savings. But just in case, how's this for a slogan? SBIRT: Services that Benefit Independents, Republicans, and Tea party members (and Democrats, too).

Project Manager Update

Alcohol 'most harmful drug,' followed by crack and heroin

Candace Peterson, Ph.D.,
WIPHL Project Manager

Recently I came across a CNN news release, shown below, which cited an online article on harm related to alcohol use, from *The Lancet,* a respected British medical journal. *The Lancet* article was co-authored by David Nutt, Britain's former chief drug adviser.

My interest was piqued, and I read through the article. The authors of the article state that "aggressively targeting alcohol harms is a valid and necessary public health strategy." Closer to home, the delivery of SBIRT services in Wisconsin is one way to pursue this important public health strategy.

The Lancet, a British medical journal, lists alcohol as the most harmful drug among a list of 20 drugs.

London, England (CNN) — Alcohol ranks "most harmful" among a list of 20 drugs, beating out crack and heroin when assessed for its potential harm to the individual imbibing and harm to others, according to study results released by a British medical journal.

A panel of experts from the Independent Scientific Committee on Drugs weighed the physical, psychological, and social problems caused by the drugs and determined that alcohol was the most harmful overall, according to an article on the study released by *The Lancet* on Sunday.

Using a new scale to evaluate harms to individual users and others, alcohol received a score of 72 on a scale of 1 to 100, the study says. It was compared to 19 other drugs using 16 criteria: nine related to the adverse effects the drug has on an individual and seven on its harm against others.

That makes it almost three times as harmful as cocaine or tobacco, according to the article. Heroin, crack cocaine and methamphetamine were the most harmful drugs to individuals, the study says, while alcohol, heroin and crack cocaine were the most harmful to others.

The article was published on *The Lancet's* website in mid-November and is slated to be published in an upcoming print edition of the journal. To view the entire article on-line, go to http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(10)61462-6/fulltext.

Access to SBIRT Update

Why Language Matters

Mia Croyle, MA
WIPHL Site Operations Team

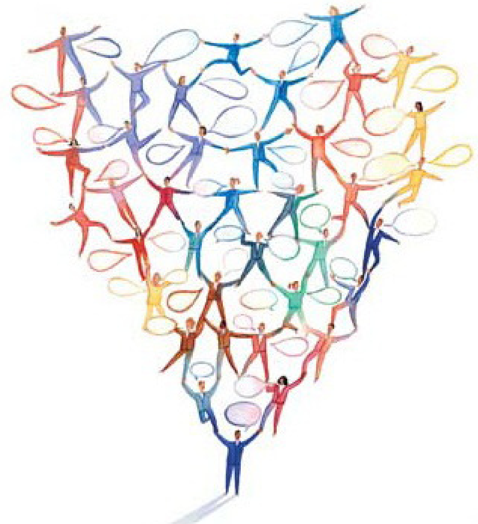
Recently I hosted a group call with the health educators where we discussed the language we use to talk about the patients we work with. As a jumping off point for our discussion, we all viewed the program, "Language Matters: Talking About Addiction and Recovery," produced as part of Road to Recovery Television Series for National Alcohol & Drug Addiction Recovery Month 2010.

SAHMSA Administrator Pamela S. Hyde has said this about the we use language: "We need to find a way to talk about prevention, health, disorders, disease, addiction, illness, and recovery so that we can address the issues and not argue about what we mean. We definitely need to use "people first" language regardless of how we describe people with symptoms, illnesses, addictions, or diseases and how we label their status." (SAMHSA News, March/April 2010)

What does "people first" language mean? Consider the difference between the following terms: "junkie," "addict," "drug abuser," and "person with a substance use disorder." What is the difference between these terms? It may seem like just a case of "politically correct" language until you consider that language is closely connected to emotion,s and words often carry unspoken meanings.

The language we use impacts the way patients perceive themselves and are perceived by others. The words we choose may increase stigma and shame associated with problems related to the misuse of alcohol or other drugs. Furthermore, by shaping perceptions, the words we use may also have implications for programs and policies, funding and laws.

The WIPHL health educators discussed ways that language comes into play in their work and how an awareness of this will help them be more conscious users of words. We agreed that we should never assume that a speaker means anything derogatory by the language they use because it could simply speak to their age or culture, or a difference in experiences. We also all agreed that it is important for us to always strive to use and spread language that promotes empathy, compassion, and accurate understanding. They were eager to find ways to spread this dialogue with others at their sites and identified ways to use this information in their daily work.



Words are important. If you want to care for something, you call it a "flower;" if you want to kill something, you call it a "weed." —Don Coyhis

One idea that was offered up really seemed to resonate with the group, and it involves a change in they way they share risk-assessment feedback with patients, as illustrated below:

Old way – "From the questions you answered, it sounds like you are what we would call an at-risk drinker."

New way – "From the questions you answered, it sounds like there are times when you are drinking in what we would consider to be an at-risk manner."

All of the programs on the Road to Recovery Television Series are available for viewing at the following site: http://www.recoverymonth.gov/Multimedia/Road-to-Recovery-Television-Series.aspx. There are also discussion guides and other great resources for each topic addressed.

Access to SBIRT Update

Drinking Guidelines

Josh Taylor, BS
WIPHL Site Operations Team

One component of a WIPHL brief intervention is sharing information on guidelines for moderate or alcohol use. The National Institutes of Alcohol Abuse and Alcoholism (NIAAA) defines "low-risk" drinking as no more than 14 drinks a week for men and 7 drinks a week for women, with no more than 4 drinks on any given day for men and 3 drinks a day for women (*Rethinking Drinking,* NIAAA, 2009).

WIPHL Health Educators share this with patients and partner with patients in a conversation about some of the risks of drinking above these guidelines.

Here is a summary of some of the health risks:

Cardiovascular Disease:
Alcohol consumption and mortality follows a u-shaped curve. This means there is evidence that suggests that 1-4 drinks daily may reduce the risk of cardiovascular disease, whereas 5 or more increases the risk of cardiovascular disease.

Breast Cancer:
The effect of alcohol on the risk for breast cancer remains controversial. Overall evidence from data seems to indicate that alcohol may be associated with an increase in the risk of breast cancer. The increase of risk is more profound in women who have a family history of breast cancer and also for those who are using estrogen replacement therapy (ERT).

Weight Gain:
The results from most well designed large prospective studies suggest that individuals who drink in moderation do not gain weight at a faster rate than non-drinkers. However, in general, all alcoholic beverages contain calories that are not a good source of nutrients and when consumed beyond an average of two drinks a day may lead to weight gain.

Birth Defects:
As research has stated for many years, alcohol at high consumption levels can cause both physical and neurobehavioral birth defects such as fetal alcohol syndrome. There are three domains that alcohol has proven to affect in offspring: growth, physical malformations and neurological/cognitive effects.

Aging:
Research into the effects of moderate alcohol consumption on Alzheimer's dementia and macular degeneration have remained inconclusive. There does not appear to be any correlation between level of impairment and blood alcohol content by the elderly. Even though their BAC increases quicker than young adults, their level of impairment stays parallel to that of younger drinkers.

To download or order copies of the Rethinking Drinking booklet, go to: http://pubs.niaaa.nih.gov/publications/RethinkingDrinking/OrderPage.htm

For more information about the research behind the NIAAA's drinking guidelines, you can access the State of the Science Report on the Effects of Moderate Drinking (2003) at: http://pubs.niaaa.nih.gov/publications/ModerateDrinking-03.htm.

Another good source of up-to-date information is the Report of the Dietary Guidelines Advisory Committee on the Dietary Guidelines for Americans (2010) which can be accessed at: http://www.cnpp.usda.gov/DGAs2010-DGACReport.htm.

Month end data

Year 5 Month 2

October 15 – November 14, 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)	109	76	69.7%	29	38.2%	54	186.2%
Aurora Sinai Women's Health Center (0.9 FTE)	152	139	91.4%	32	23.0%	37	115.6%
Aurora Walker's Point (0.9 FTE)	165	165	100.0%	65	39.4%	67	103.1%
Beloit Area Community Health Center	66	64	97.0%	24	37.5%	27	112.5%
Columbia St. Mary's	96	96	100.0%	32	33.3%	27	84.4%
Family Health/ La Clinica (0.5 FTE)	120	115	95.8%	36	31.3%	9	25.0%
Gundersen Lutheran Family Med	306	293	95.8%	77	26.3%	32	41.6%
Gundersen Lutheran Trauma Center	83	N/A	N/A	N/A	N/A	78	94.0%
Menominee Tribal Clinic	635	500	78.7%	73	14.6%	60	82.2%
Milwaukee Health Services, Inc. (0.3 FTE)	19	2	10.5%	2	100.0%	1	50.0%
Northeast Family Medicine	286	241	84.3%	73	30.3%	68	93.2%
Scenic Bluff's Community Health Center (0.2 FTE)	24	23	95.8%	8	34.8%	0	0.0%
St. Joseph's Community Health Services	48	48	100.0%	14	29.2%	11	78.6%
Waukesha Family Practice Center	259	246	95.0%	64	26.0%	61	95.3%
Grand Totals	**2,368**	**2,008**	**84.8%**	**529**	**26.3%**	**532**	**100.6%**

*Eligibility varies by clinic

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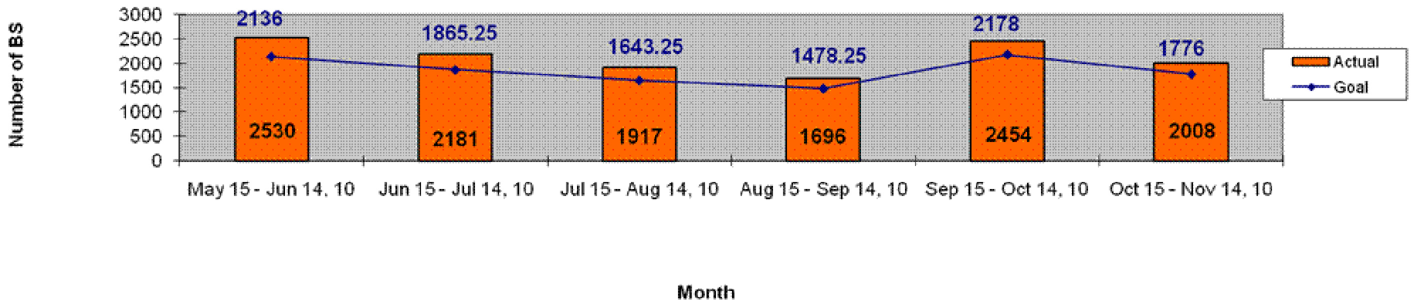
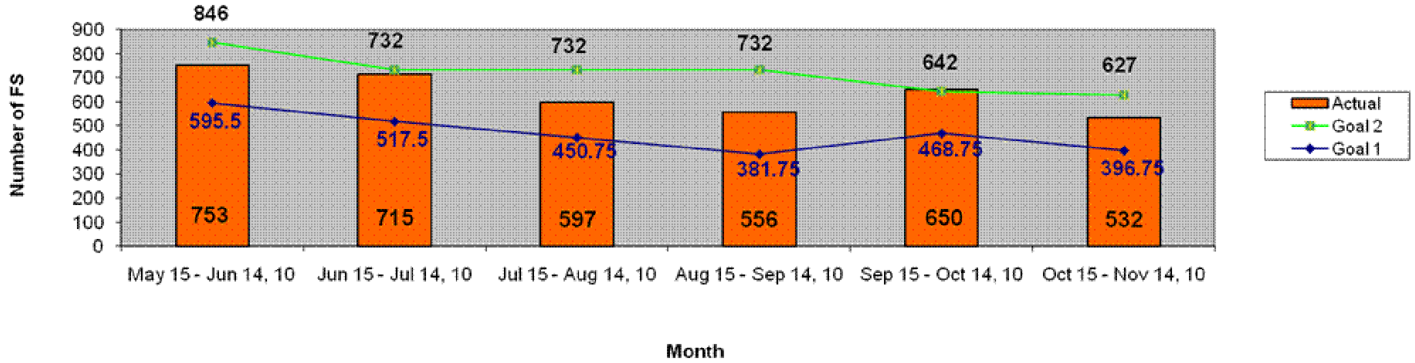
6 month wrap-up



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



Actual: Number of full screens completed
Goal 1: Year 5 (Sept 15, 2010 - May 14, 2011) - Full screen 75% of patients who brief screen positive
Goal 2: Year 5 (Sept 15, 2010 - May 14, 2011) - Number varies by site based on start date

Cultural Competence Update

Refugee Mental Health

Kevin Browne, Ph.D., WIPHL Consultant on Cultural Competence

Refugees from a wide range of countries have settled in Wisconsin and elsewhere around the U.S. Fleeing armed conflicts, natural disasters, and political persecution, refugees face a host of barriers in obtaining meaningful and important health care services. Refugees have arrived in recent years from Southeast Asia (Burma, Laos, Cambodia, Vietnam), the Balkans (Bosnia, Serbia, Croatia), Russia, Afghanistan, Iraq, Palestine, several African countries (including Sudan, Somalia, Congo and Liberia), and Haiti, among others.

The resettlement process entails a major uprooting of lives, and for many refugees creates economic, social, and psychological hardships. These include changing roles in the family between spouses and in parent-child relationships, financial stress, and difficulties with language and acculturation. These stresses and adjustment difficulties can lead to domestic violence, substance abuse, major depression, sleep problems, anxiety, and a range of somatic symptoms, on top of the problems such as PTSD that many refugees experience from events in their home countries.

Barriers to access and utilization of health care services among refugees in the U.S. include lack of familiarity (navigating health care bureaucracies, the concept of specialized care, with the disease model, etc), perceptions of an unfriendly environment, language barriers; fear of gossip in their isolated refugee community; lack of experience with the counseling process and perceived stigmas of mental illness; cultural idioms of distress that do not converge with biomedical explanations; lack of follow-through with medical recommendations; and so forth.

Culturally competent health services for refugees involves creating effective linkages at every step of the process, from creating a welcoming environment, to building trust via word of mouth, the appropriate use of interpreters, culturally appropriate services, help navigating health care bureaucracies, and dialogue with various refugee communities.

Resources:

The Wisconsin Department of Workforce Development has a Refugee Assistance program that assists families with employment, with obtaining financial and other assistance, and with mental health needs: http://dcf.wisconsin.gov/refugee/default.htm

Wisconsin DWD has also sponsored conferences on Refugee Health. Presentations and further resources from a 2010 Refugee Health Training Conference are available at: http://dcf.wisconsin.gov/refugee/health_links.htm

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The Last Word

From a health educator in southeastern Wisconsin

A pregnant mother who had previously suffered two fetal demises was seen by the WIPHL health educator. The patient shared that with this new pregnancy she had a renewed desire to stop using crack cocaine. She met repeatedly with the health educator over the course of the next few weeks and was successfully referred to a treatment program. She is attending outpatient treatment for the first time in her life and is glad to be taking steps toward a healthy pregnancy.

The WIPHL Word 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 our editor, Chanda Belcher, at chanda.belcher@uwmf.wisc.edu.