The WIPHL Word

October 4, 2007

The Director's Desk

Transitioning from Start-Up to Maturation

By Richard L. Brown, MD, MPH

On September 15, WIPHL celebrated its first birthday. Birthdays are great times to take stock, review the past year, and look forward to the next one, so that's what I'll do in this column.

Clearly the need for WIPHL continues. Wisconsin recently was ranked first, once again, in risky and heavy drinking. Alcohol and drug use are the fourth most common causes of death and hospitalization in this state. Drinking and drug use are involved in a substantial proportion of car crashes, other injuries, violence, family dysfunction, child abuse and neglect, and other suffering. Drinking and drug use also contribute to and impede treatment of many medical problems that are commonly encountered in primary care settings, including hypertension, diabetes, heart disease, GERD, sleep problems, depression, other mental health disorders, hepatitis, HIV/AIDS, and more. Good health care requires good care for risky and problem drinking and drug use. Screening, brief intervention, referral, and treatment (SBIRT) services must become a routine part of primary health care in Wisconsin and across the United States.

In our first year, our first task was hiring, orienting, and training staff. After some frustrating bureaucratic delays, we finally had a full complement of staff in April. All staff members have worked hard to establish our physical infrastructure—including an office and a computer network—along with the critically important collaborative, legal, and regulatory infrastructure we have with the Wisconsin Department of Health and Family Services, our umbrella organizations, and our participating clinics. The other major emphasis over the past six months has been to initiate and enhance access to

SBIRT services. We've focused especially on enhancing delivery of the brief screen and having our health educators provide full screens for patients with positive brief screens.

Our successes are reflected in the goals we set for Year 1. Nearly 20,000 patients completed brief screens during Year 1. Of those, about one-third, or 6,000 patients, screened positive on an alcohol or drug question. Ideally most of those patients would have received a brief intervention or referral, but we reached only about 1,300 of them with intervention and referral services—partly because many patients with positive brief screens are not getting to see health educators, and partly because of delays in developing and refining our service protocols and computer tablet system. And although we've all made great strides in reaching more and more patients over time, we still have more work to do on analyzing the quality of services we're delivering.

As we move from infancy toward maturity, we must meet new goals while maintaining and building on previous successes. The goals to aim for must be guided by our ultimate goal of sustainability—that WIPHL will survive and continue to ensure the routine, systematic delivery of SBIRT services in primary care long after WIPHL funding expires in 2011.

Our goal of sustainability will be greatly enhanced in this coming project year as reimbursement for SBIRT services becomes available in primary care settings. Reimbursement levels are expected to be commensurate with compensation for skilled, well-trained (though not necessarily, for this position, formally licensed or certified) health educators who will be regarded by state regulators as ancillary to physicians, nurse practitioners, and physician assistants. Reimbursement will come first from Medicaid and Medicare, and later from private insurers. Our goal is that our clinics will achieve financial sustainability by next summer.

Financial sustainability will require efficiency. Sustainability will be possible only at clinics where WIPHL health educators are usually busy providing direct, billable SBIRT services. Clinics will need to keep their health educators busy seeing patients by ensuring systematic completion of brief screens and systematic referral of patients with positive brief screens to their health educators. We estimate that clinics whose health educators are providing billable services during 75 percent of their professional time will find that they can support health educators without WIPHL funding, so this is our goal for all clinics.

At the same time, we will need to document for payers and ensure for ourselves that WIPHL is providing services of high quality. Ensuring and documenting quality of care is a tremendous issue for all health care providers, but WIPHL will have an especially high burden of proof because SBIRT services are new to potential payers and because most of our health educators are not licensed by the state of Wisconsin as substance abuse counselors. We will meet this challenge by (1) continuing to document the care

our health educators provide by audiotaped reviews, (2) completing our computer tablet system, which will document that all WIPHL patients are receiving SBIRT services as guided by evidence-based protocols, (3) conducting focus groups of WIPHL patients to identify ways to improve services, (4) inaugurating an interactive voice response system by which WIPHL patients will indicate their satisfaction with WIPHL services, and (5) tracking patient outcomes via six-month follow-up interviews with 10 percent of our patients and via information collected at follow-up visits to health educators.

So, this year we aim that WIPHL will:

1. Continue to expand service delivery by reaching more patients at current clinics and commencing service delivery at new clinics.

2. Conduct Plan-Do-Study-Act cycles on additional aspects of WIPHL, such as the volume of brief interventions and treatment referrals we provide, and time between full screening and treatment entry for dependent patients.

3. Implement procedures for gaining reimbursement for SBIRT services and sharing such reimbursement between WIPHL and its participating clinics.

4. Intensify our policy work to enhance demand for SBIRT services by payers and enhance the receptivity of health care professionals and settings to SBIRT services.

One of our funding agency's site visitors reported in July that "WIPHL is the best designed and most advanced SBIRT program I have visited in the first year of operation. … Nevertheless, there remains much work to be done."

It is not easy to build durable systems to improve services for one of Wisconsin's most vexing public health problems. Stresses and strains are inevitable, and I'm sure that good communication will lead to solutions.

If you're a part of WIPHL, thanks very much for being part of the solution; it's great to be working with you! If you're not a part of WIPHL—please join us!

Conference Kudos

Thanks to all who attended the statewide conference! Your engagement made it a success. Look for a compendium of the meeting on our website by the end of the month. Special congratulations to:

- Polk County Health and Human Services, winners of the Traveling Vision Award

- Skit Group 3 (Amery Regional Medical Center, Polk County Health and Human Services, and Mercy Clinic South) for "best skit" on our Applause-o-Meter
- Jeopardy champion Mia Croyle
- "Best Wig" award goes to Christina Lightbourn

Have You WIPHL'd Anyone Today?

Health Educator Update

The staff at the Amery clinic refer to their health educator, Mary Boe, as "Mrs. WIPHL." Mary and the 17 other health educators statewide have the incredible responsibility of being the face of WIPHL to our customers, the patients.

When Karen Timberlake, Deputy Secretary of the Wisconsin Department of Health and Family Services, spoke at our fall statewide meeting she said, "The work you are doing is literally life-saving." While this is a tribute to all WIPHL partners, it is the health educators who in the end have the opportunity to make the biggest difference in the lives of their patients. Those of us in the wings can help by making sure that the HEs have everything they need to provide those services.

The WIPHL Coordinating Center (CC) has always made support for and communication with the health educators a high priority. In response to comments at the meeting and internal discussions, we will make some changes in the way that we support the HEs. Starting immediately, instead of one large group meeting, Laura Saunders will meet with the HEs by wave. (See WIPHL Calendar in this newsletter for new schedule.) There are several reasons why this makes sense. The health educators are more likely to be comfortable talking directly with the people they got to know during training. Also, we are finding that issues tend to cluster by wave. Finally, those who are just starting need additional time to talk.

Laura will continue to talk one-on-one with every health educator for up to one hour each month. Following each of those meetings, Laura will communicate directly with the clinic manager at each site with a short summary of how the HE is doing from the CC perspective and an invitation to share comments back.

We will convene the large group of health educators for topical meetings at least six times a year. There were a number of training issues that came out of the meeting. The most immediate training needs will be addressed first.

We are working to increase access to more technical support for the computer tablet—more of a one-stop-shop for assistance with tablet and application issues.

Finally, we will be working with all partners and staff to assure that the HEs are freed up to do what they were trained to do—provide screening, brief intervention, and referral to treatment for primary care patients. Understandably, in the beginning of the project, the HEs often took on administrative or QI roles, but once a clinic is up and running, those roles need to be reallocated to free the HEs up to provide direct care.

Our HEs are a tremendous group of individuals. They came to the program with a myriad of experiences and expertise in the arena of substance use disorders. We have invested in them with continued support and training. They are one of our biggest assets in the world of WIPHL.

Health Educator Spotlight

In the spotlight: Diane Carlson

My clinic and the people I serve: I work at the Menominee Tribal Clinic, which is located right on the Menominee Indian Reservation in Keshena, Wisconsin. The clinic patient base is over 98 percent Native American. We have a very unique clinical setting because we can serve all health needs of the Native population in one facility. Along with the medical department, the clinic has a pharmacy, laboratory, and radiology department to serve medical needs. The clinic also offers dentistry, optometry, mental health services, wellness, nutritional services, community health services, women's personal health services, physical therapy, and emergency medical services. Altogether we have 146 employees, with 125 of them full time and 21 part-time or on call. The reservation also has a tribally owned wellness and treatment center that has been accepting our WIPHL referrals.

What works for me and my patients: The success we have had at our clinic is in large measure due to our nursing staff. They have been great about handing out the brief screens as they room their patients. They are also very persistent; they are handing out screens at all patient visits, even if the patient has filled one out before. We have had many patients that asked not to be contacted at their initial screen actually go through the protocol after a second screen had been given to them. Another big advantage for us is that our entire WIPHL team is employed at the clinic and is available daily. Meetings are very easy to schedule. When we first implemented WIPHL, as you have all experienced, many things needed to be tweaked and reevaluated, and this process was much easier with all team members being available at short notice. Finally, I think some of our success has come from the fact that I had worked with this patient base for nearly five years before the WIPHL project started. The staff was familiar with me and the patients knew me as someone they could trust.

One thing I do that might be helpful elsewhere: If I had one tip for other clinics, it would be the persistence I learned from our nurses. Any time we can complete even the smallest piece of the protocol, it is beneficial to our patients. Most patients are not ready to jump right into this sort of program; often taking small steps is the way to reach patients. Always remembering to recognize any progress the patient achieves is also very important.

I knew my work really mattered when: Recently I had two different patients who told me that they did not want to continue with the protocol past the screening get hold of me and ask to schedule appointments. They realized that alcohol was causing many problems in their lives. Just hearing someone actually say "I need your help" is very eye-opening. To know that you have the ability to help the patients you serve and know that they value the service you are providing is very rewarding.

Cultural Competence Update

By Harold Gates

Cultural Competence was well represented in the agenda at our statewide meeting. Our health educators were able to benefit from Dr. Denice Cora-Bramble's expertise as a primary care physician who practices using the principles of cultural competence. Dr. Cora-Bramble is the Executive Director of the Goldberg for Community Pediatric Health in Washington, D.C. She presented an afternoon workshop that had as its main components and objectives: case-based learning; interactive session; video vignettes; practical clinical applications; evidence- and research-based practice; and learning community.

She was very adept at weaving together all of the components into a rewarding session for our health educators. She then came back the following day—Sept. 27, the first day of the conference proper—as our keynote speaker and shared her thoughts on the need for continuing our pursuit of cultural competence on a project-wide level. Dr. Cora-Bramble talked about making the case for cultural competence, knowledge gaps, and the provider/clinician's role in a primary care setting. She ended with some pointers on professional development.

We had sent out e-mails regarding upcoming cultural competence learning opportunities. First, there is an upcoming DHFS Tribal Affairs conference coming up on October 29-31 in the Wisconsin Dells. This conference is co-sponsored by DHFS and American Indians Against Abuse and will take place at the Ho Chunk Hotel and Convention Center. The Bad River Band of Lake Superior Chippewa will serve as host.

There are a number of other learning opportunities available in the coming months. I will be sending along links to these by the end of the week. One in particular is the biannual Georgetown University National Technical Assistance Center for Children's Mental Health. Calls for Proposals are due October 25, 2007 if you are interested in presenting as part of their public health track. Finally, the Cultural Competency Committee and the Protocol Subcommittee continue progress on their respective work plans and projects and will give updates as the work moves forward. We would like to welcome Kerri Weberg, our HE at Marshfield Clinic Minoqua Center, to our next meeting and invite others to join us in this important work. Our next meeting will take place on October 19 from 12-1:30 p.m.

The Clinic Corner

Clinics	Eligible for BS*	Completed BS	% BS Completed	Positive BS	% Positive BS	Completed FS	% FS Completed
Wave 1							
Augusta	297	82	28%	17	21%	0	0%
Belleville	172	135	78%	50	37%	11	22%
Eau Claire	533	133	25%	53	40%	14	26%
Northeast	169	138	82%	46	33%	33	72%
Polk County	N/A	139	N/A	56	40%	26	46%
St. Joseph's	208	194	93%	45	23%	25	56%
Wingra	267	170	64%	67	39%	15	*22%*
Totals	*1,646*	*991*	*N/A*	*334*	*34%*	*124*	*37%*
Wave 2							
Amery	N/A	262	N/A	101	39%	25	25%
FamHlt/LaCl.(0.5 FTE)	76	76	100%	12	16%	4	33%
Menominee	357	269	75%	124	46%	35	28%
St. Croix RMC	4325	383	9%	111	29%	26	23%
St. Croix Tribal	23	6	26%	4	67%	1	25%
Totals	*4,761*	*976*	*N/A*	*346*	*35%*	*91*	*26%*
Wave 3							
Mercy Clinic South	521	146	28%	51	35%	27	53%
Sinai Family Care Center	143	79	55%	12	15%	6	50%
Sinai Internal Medicine	197	132	67%	26	20%	11	42%
Walker's Point	280	192	69%	68	35%	13	19%
Waukesha	412	177	43%	60	34%	25	42%
Totals	*1553*	*726*	*47%*	*217*	*30%*	*82*	*38%*
Wave 4							
Fox Valley	235	157	67%	46	29%	14	30%
Minocqua	10	10	100%	2	20%	1	50%
St. Luke's	N/A	74	N/A	18	24%	8	44%
Totals	*245*	*241*	*N/A*	*48*	*29%*	*15*	*31%*
Grand Totals	**8,205**	**2,860**	*N/A*	**969**	*33%*	**320**	*33%*

*Criteria for eligibility varies by clinic

Clinic Corner Commentary

In the face of a new software build for the tablets and time out of clinic for continuing education and the semi-annual meeting, WIPHL health educators managed to launch or re-launch services at three new sites: **UW Fox Valley, Marshfield Clinic Minocqua Center,** and **Aurora St. Luke's**, as well as and continue service delivery at existing sites. Way to go, UW Fox Valley, for not only getting off to a robust re-launch but also making a successful referral to treatment for a patient.

UW Northeast, Polk County, St. Joseph's Wonewoc/Elroy/Hillsboro, Amery Regional Medical Center, Menominee Tribal Clinic, St. Croix Regional Medical Center, Mercy Clinic South, and **Waukesha Family Practice Center** deserve a big round of applause. The health educators and their teams at the clinics were able to meet and exceed expectations in September in the face of time out of clinic and time spent learning and adjusting to a new tablet build. This speaks well of the implementation in the sites to systematically deliver SBIRT services and the hard work of health educators.

UW Belleville, UW Eau Claire, UW Wingra, St. Croix Chippewa Tribal Clinic, Aurora Sinai Family Care Center, Sinai Internal Medicine, and **Walker's Point** have also demonstrated their hard work this month. In the face of major electronic medical record changes, significant service delivery changes in Plan-Do-Study-Act cycles, and adjustments to changes from the coordinating centers, these clinics have stayed engaged, built on their successes, and continued to deliver much-needed services to patients.

Sites reached several major milestones this month. As a program, we can all be proud of our shared accomplishments!

QI Tips

Meet Regularly
Even if your team couldn't be more satisfied with your service delivery outcomes, it is important for WIPHL QI teams to meet regularly. Maintaining successful implementation, buy-in, and quality requires communication and a team effort. Two successful strategies shared by clinics for consistent meetings are:

1) Piggy-backing on an existing clinic meeting where key stakeholders participate and there is sufficient time to discuss WIPHL

2) Set a standing monthly meeting that the entire QI team knows about in advance and use the QI worksheet to monitor progress and celebrate successes or address a specific barrier

Individualized Goal-Setting for Clinics
At our semi-annual meeting, clinics and WIPHL Coordinating Center staff participated in listening sessions that focused on strengthening partnerships and discussing Year 2 goals. This year, QI service delivery goals are based on percentages rather than a universal program-wide implementation goal. Lilly will be in contact with umbrella organizations and clinics to build consensus around Year 2 goals. Please be thinking about the following questions to inform our goal-setting efforts.

1) Who are we focused on serving through WIPHL services? (Does your team have a projected number of patients that meet the eligibility requirement your clinic has established to participate in WIPHL?)

2) What does our team know about the significance of the need for services at our clinic? (Please review the average percentage of positive patients for Year 1. If you did not deliver services in Year 1, consider that the average in Wisconsin for positive brief screens is 25 percent. Program-wide the average this month was 33 percent of patients screening positive for risk on alcohol and drug questions.)

3) How is our site doing in terms of responding to patients who screen positive on the brief screen and are eligible for additional WIPHL services? (Please look at the average % of patients who complete the full screen over the period of time your clinic has delivered WIPHL services.)

Each clinic's ability to address these key QI issues in a step-wise fashion will result in improved patient access to much-needed WIPHL services and improved health outcomes for patients.

Innovations
UW Wingra is trying something new. At the semi-annual meeting, Julia Yates and the WIPHL QI team from Wingra shared an approach they're trying. Each day Julia and her team determine a provider that Julia will shadow. Julia delivers the brief screen to all of that provider's eligible patients face-to-face on that day. If a patient scores positive, Julia does a full assessment, brief intervention, and does the groundwork for appropriate follow-up. The rest of the clinic continues to universally brief screen patients and make referrals of positive patients. Time will tell how this strategy is working, but it is promising so far.

WIPHL People

We're pleased to welcome four interns on board. Ann Goth is a student at Madison Area Technical College in the area of social and human services. Her work with WIPHL will emphasize supporting efforts in cultural competence. Ann will be with us for the entire

school year. From the physical therapy program, we welcome Jen Schumacher, Meghan Feih, and Vanessa Kuehl. They will be with us for the fall semester and primarily work to support our evaluation team with data entry.

WIPHL Calendar

October 5, 8:30 a.m.—Executive Team Meeting
October 9, 12 p.m., Tuesday—Health Educators' Meeting, Waves II and III
October 10, 9 a.m., Wednesday—Health Educators' Meeting, Wave IV
October 10, 12 p.m., Wednesday—Health Educators' Meeting, Wave I
October 11, 2 p.m.—QI/Implementation Team Coordinators' Meeting
October 16, 12 p.m., Tuesday—Health Educators' Meeting, Waves II and III
October 17, 9 a.m., Wednesday—Health Educators' Meeting, Wave IV
October 17, 12 p.m., Wednesday—Health Educators' Meeting, Wave I
October 19, 8:30 a.m.—Executive Team Meeting
October 19, 12 p.m.—Cultural Competency Committee Meeting
October 23, 12 p.m., Tuesday—Health Educators' Meeting, Waves II and III
October 24, 9 a.m., Wednesday—Health Educators' Meeting, Wave IV
October 24, 12 p.m., Wednesday—Health Educators' Meeting, Wave I
October 30, 12 p.m., Tuesday—Health Educators' Meeting, Waves II and III
October 31, 9 a.m., Wednesday—Health Educators' Meeting, Wave IV
October 31, 12 p.m., Wednesday—Health Educators' Meeting, Wave I

The Last Word

Missing Your Son's Wedding—An Occasional Drinker's Story

From a Madison clinic:

I met with a 53-year-old man yesterday who scored as "at risk" after completing the full screen. He is what I call a "special occasion" drinker—someone who typically doesn't drink at all, occasionally has a few drinks but stays within the low risk recommendations, and on the rare instance (maybe once or twice a year) has more than the recommended amounts.

In speaking with this man, he shared with me that the last time he drank more than five drinks was last month at his son's wedding. He told me that he really regretted drinking as much as he did at the wedding. He told me that he drank so much that night that he didn't remember large portions of the reception. He told me "I really wish I hadn't drank that much. That was such a special night—he's my only son and I hope this is his

only wedding. That night is lost to me and there's no way I'll ever get it back." He was close to tears as he shared this with me.

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