The WIPHL Word

Wisconsin Initiative to Promote Healthy Lifestyles

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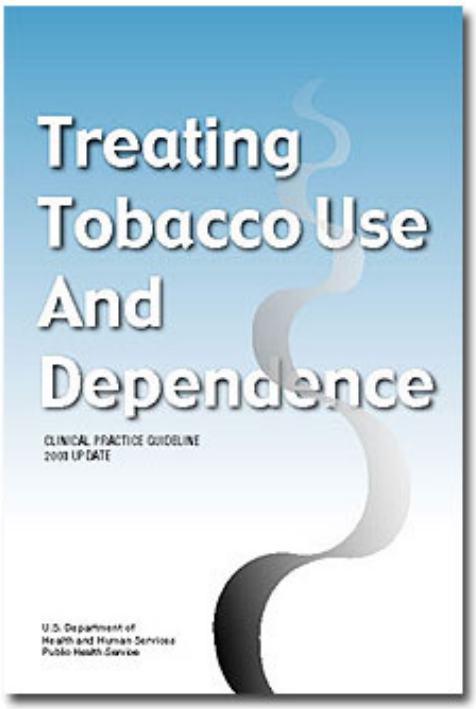
The Director's Desk

Research Support for the WIPHL Model —and Future Challenges

By Richard L. Brown, MD, MPH
Clinical Director

There have been more than 50 randomized controlled trials showing that brief interventions are effective for risky and problem drinking. Three studies suggest that brief interventions can be effective for drug use. Three other studies show that SBIRT services generate substantial return on investment and significant healthcare savings within 12 months. That's a lot of great research on the effectiveness and cost-effectiveness of SBIRT services. But there's not much research to guide us on how best to systematically deliver these services.



For now, though, perhaps we can extrapolate some lessons learned from the tobacco literature. The 2008 update of the Public Health Service's clinical guideline on tobacco services summarizes the results of many dozens of studies.

Here's what they found. Systematic screening makes a difference. Many more patients receive interventions, and the one-year abstinence rate doubles from 3% to 6%.

To a point, providing multiple intervention sessions for nicotine-dependent patients can be very helpful. Abstinence rates increase steadily from 12% to 25% as the total number of sessions increases from one to more than eight. Optimal total contact time falls somewhere between 30 and 90 minutes. When medications are added, abstinence rates can improve further even with smaller numbers of sessions.

Interestingly, while rates of abstinence were slightly higher when physicians administered the tobacco intervention, the improvement over non-physicians was not statistically signficant. And abstinence rates were higher when more than one individual addressed tobacco use with patients.

This research nicely supports much of our model. We strive to screen all of our patients yearly. Our health educators provide services to many more patients than can physicians, nurse practitioners, and physician assistants because there are so many other demands on those clinicians' time. And providers are hopefully taking small amounts of time to reinforce the discussions that patients have with their health educators.

The tobacco research also poses some challenges for us. What can we do to encourage more follow-up visits for our alcohol- and drug-dependent patients? What can we do to enhance their access to medicines (oral naltrexone, long-acting injectable naltrexone, acamprosate, and buprenorphine), which clearly bolster outcomes?

In upcoming issues, I'll share some success stories in these realms at some of our WIPHL clinics. In the meantime, please let me know if you have any suggestions—and thanks so much for your support for WIPHL.

Project Manager Update

Strategic Planning and Sustainability

By Candace Peterson

First, congratulations to our three new health 3ducators who completed training in March: Jenni Hamann, with Dean Health System Sun Prairie–Family Medicine; Kathryn Schleis, with Marshfield Clinic–Park Falls Center; Joshua Taylor, with Upland Hills Health–Emergency and Urgent Care in Dodgeville. These three health educators and their clinics are already up and rolling. Best of luck!

As the project manager of WIPHL, one of my main roles is to help the WIPHL Coordinating Center team be efficient and effective in the administration and implementation of the SBIRT initiative in Wisconsin. At this midway point in our five-year federally funded initiative, our team acknowledged that this is a good time to take stock of what we have accomplished and what we need to accomplish. With the help of Dr. John Higgins-Biddle, a technical assistant provided by our federal funder (SAMHSA), and Barb Hummel, an excellent consultant/facilitator, our team embarked on a strategic planning process designed to:

- Assess our team's accomplishments to date;
- Identify near-term tasks that need to be completed to effectively deliver the SBIRT initiative;
- Identify areas in which we as a team need to improve, change, or grow;
- Create a plan for working together to address tasks and needs; and
- Focus on sustaining demand for SBIRT and SBIRT services after the grant-funded SBIRT activities end (a clear expectation of our funder).

As a result of our strategic planning process, the WIPHL Coordinating Center team has identified and begun work on both current and future SBIRT. In the last six weeks, we have already reorganized to increase our ability to effectively and efficiently coordinate and implement the current grant efforts, including:

- The formation of new role/function-focused work teams;
- The adoption of new team meeting practices to improve coordination between teams, team task assignments, and follow-through;
- The selection and implementation of a new internal decision-making model; and
- The selection and implementation of a new work planning system.

Part of the focus of the strategic planning process was also to explore ways to sustain SBIRT services in Wisconsin after the end of grant funding. We are continuing to focus in this area on efforts designed to:

- Promote demand for SBIRT services;
- Encourage governmental/business policies and practices that will support SBIRT services, including reimbursement for services; and
- Create local, state, and national awareness of SBIRT's critical role in reducing healthcare costs.

In a preface to his recent report to SAMHSA on WIPHL's planning process, John Higgins-Biddle wrote:

> "The decision to conduct this planning process and investigation early in Year 3 of the grant may simply have been a result of sound management. However, it may also have resulted in part from the design of the WIPHL program, which provides resources to primary care practices to supply service personnel who receive WIPHL support. Thus, the task was not simply how to continue the organization that the SBIRT grant had created, but more importantly how to continue the services that the grant had allowed to be initiated."

> "As the report makes clear, I trust, this is an exceptional SBIRT program. Their choosing to pursue strategies to sustain SBIRT services and the methods they have adopted to develop those strategies sets them apart from all other programs I have tried to help."

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Higgins-Biddle continued, "However, this path down which they have started is both long and complicated. It is critical that this work succeed to establish a model by which SBIRT service delivery can become an ongoing part of our healthcare system. Given the fact that all state SBIRT projects should develop means to sustain services beyond the five-year term of their grants, it is worth considering whether this process should be mandatory for all grantees. I would strongly urge that some form of strategic planning for sustaining services be required of all programs in every year of operation. The method developed and used by WIPHL was extremely well done and will, I believe, prove effective."

Thank you to all of our WIPHL colleagues, partner clinics, and stakeholders around the state for helping the Wisconsin SBIRT initiative achieve a national reputation. As we look to the future, we are so pleased and excited to continue to partner with you to bring SBIRT services to Wisconsin.

Sign Up Now for May Teleconferences

The *WIPHL Speaker Series* continues with two talks in May.

Our first presentation is a **WIPHL Tablet Software Demonstration** designed specifically for the non-health educator. Have you wondered what the WIPHL software looks like and how a health educator uses the software when working with a patient? See the application used by the health educator and have an opportunity to ask questions. Our presenter is Holly Prince, WIPHL manager of clinical protocols.

When: Thursday, May 7, noon to 1 p.m.

Our second offering focuses on **Trauma-Informed Services,** presented by Elizabeth Hudson, LCSW, trauma services coordinator at the Wisconsin Department of Health Services. Hudson plans to discuss the broad philosophy of trauma-informed care as well as general guidelines for trauma-informed practice.

When: Tuesday, May 19, noon to 1 p.m.

Where: At your desk! (Free teleconferences, with materials to be made available beforehand.)

How to register: Go to Wisline registration: http://www.uwex.edu/ics/wlreg/wlwelcome.cfm. If you do not already have an account, you will be guided through steps to create one. If you have any registration questions or problems, please contact Wisline at 608/262-0753 or e-mail wislineaudio@ics.uwex.edu. For any other questions, please e-mail info@wiphl.org for the May 19 talk and Holly.Prince@fammed.wisc.edu for the May 7 talk.

PLEASE NOTE CONCERNING MAY 7 ONLY: Five minutes prior to the tablet demonstration, go to http://www.joingotomeeting.com. Type in the Meeting ID: 581-948-139. Follow the easy directions on the screen. If you have questions, feel free to call in to the teleconference and ask for help.

Please sign up at your earliest convenience—waiting until the last minute can result in event cancellation or unnecessary charges to us.

Health Educator Update

MI Back to Basics

By Laura Saunders

Faced with a relatively light HE weekly call agenda, I decided to review the basics of MI. Using some of the material from my online MI course (http://www.browndlp.org/miskillsann.php) we reviewed the four principles and identified the concepts in a transcript. A short review of that material is below.

Four principles of MI:

1) Express empathy

Being able to express empathy is crucial.

Empathy is NOT: having had the same experience of problem, identification with the client or "Let me tell you my story."

Empathy is: the ability to accurately understand the client's meaning.

One way that we can show empathy is by reflecting back what the client said.

Why does empathy matter?

Interviewers who show high levels of empathic skill have clients who are:

• Less resistant

• More likely to stay in programs

• More likely to change behaviors

• Empathy is the single best predictor of a higher success rate in addictions work

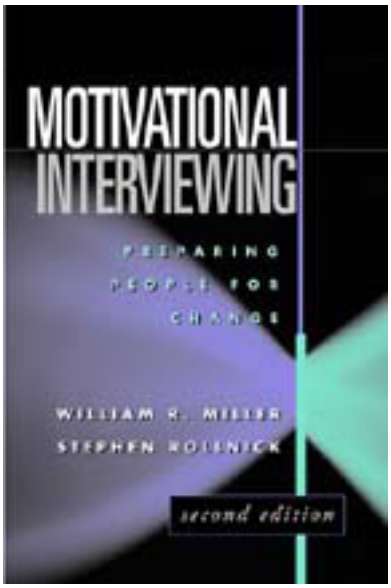
Empathize with ambivalence and the pain of engaging in negative behaviors. People want to be healthy and make good choices.

2) Develop Discrepancy

The person rather than the helper should make the arguments for change. The purpose of developing discrepancy is for the client to experience a tension between their current behavior and where they want to be.

3) Roll with Resistance

• Change strategies in response to resistance. If what you're doing raises resistance, stop and try something else.



• Acknowledge reluctance and ambivalence as understandable

• Reframe statements to create new momentum

• Engage patient/client in problem solving

4) Support Self-Efficacy

As practitioners, we have to believe that people can change and demonstrate this verbally with our clients. We can look for genuine strengths in our clients and remind them that we think they can change. This is important because as a part of MI we point out the problems—the self-efficacy (I can do something about this) provides them with an exit door.

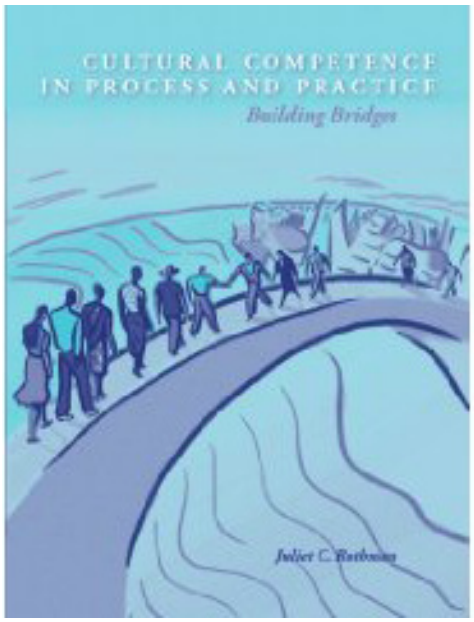
The WIPHL health educators use the principles of MI in their work every day. The tablet guides them in their interactions—providing them with the questions to ask to assess risk and collect GPRA (Government Performance Reporting Act) data. But the tablet can't always support them in their embodiment of all of the principles. We at WIPHL support this with ongoing educational opportunities such as the upcoming HE retreat and one-on-one coaching sessions. As a group, the WIPHL health educators are fine MI practitioners.

Cultural Competence Update

Recommended Reading

By Harold Gates

I have recently come across a new textbook that can also serve as a handbook on cultural competence. The book is entitled *Cultural Competence in Process and Practice: Building Bridges*, by Juliet P. Rothman (Allyn & Bacon, 2008). The essence of the book contains a conceptual framework that can assist us in a process of immersion that will help us become more culturally competent on a professional and organizational level. The model comes out of the School of Social Work at the University of California, Berkeley. It was piloted by students in their field placements and can give us insight into how they were able to grow in terms of their own cultural competence and professional development. The model is not only useful in an academic setting but can be modified for use in our healthcare settings as well.



Juliet Rothman looks at a two-part process that is based on knowledge acquisition about any group or population as a necessary prerequisite to culturally competent service delivery. This process can take place on various levels —from individuals, groups, organizations, communities, and state and national policies and programs to international health and social programs and interventions. The basic structure provides for two separate but related efforts:

1. Knowledge acquisition relative to a specific group or population through cultural immersion in that population.

2. The assessment of agency/organization, programs, and services, and personal cultural competence grounded in the knowledge acquired from the immersion experience.

Part I, Knowledge Acquisition: defines a process used with any population; in any context of practice, at the micro, mezzo and macro level, at any time in any professional setting. Each step is designed to provide another dimension of knowledge. It provides a structured approach to helping us "step outside our comfort zone" and feel "safe" in the process.

Part II, Application of Knowledge: assessing agency, programs and services, and personal cultural competencies provides guidelines for an insightful look at a population in which you have immersed yourself and lets you explore that population's experiences with service delivery. Such areas as Access, Outcomes, and Quality can systematically be looked at through the lens of cultural competence. This section also helps you look at your own personal cultural competency skills to make sure that they are addressing the needs of the populations you have studied. Finally, all of the effort put into this immersion process is measured using National Association for Social Work (NASW) Standards for Cultural Competence. This helps us know where we are in terms of supporting our professional standards and what areas are still open for improvement.

I highly recommend this book because you can work at your own pace and level of comfort as you move up the continuum of cultural competence.

Learning Opportunity

I encourage you to take a look at Special Olympics website, which has started a national campaign to "spread the word to end the word." It provides information and resources to help stop using the "R" word for people with disabilities. You can review and use the information or pledge to assist their efforts and their athletes. The website URL is www.r-word.org/.

As always, if you have any questions or need technical assistance, you can reach me at Harold.Gates@fammed.wisc.edu or by phone at (608) 265-4032.

Access to SBIRT Update

Forging Health Educator/Treatment Connections

By Mia Croyle

This month I joined the Milwaukee-area health educators for a meeting with the WIser Choice program. Janet Fleege, Milwaukee WIser Choice project director, and Gena de Sousa, integrated services manager, generously shared their time with us. This was a valuable learning opportunity for me and the health educators. It is my hope that an increased understanding of local treatment resources will further enhance our health educators' abilities to motivate and prepare patients for treatment.

Top row, from left: Health educators Susan Bush (Aurora Mayfair), Melissa Barth (Aurora Walker's Point), Christine Casselman (Aurora Sinai), and Alice Spann (Milwaukee Health Services).
Bottom row, from left: WIser Choice's Janet Fleege, project director, and Gena de Sousa, integrated services manager.

WIser Choice stands for **WI**sconsin **S**upports **E**veryone's **R**ecovery Choice. It is Milwaukee County's public treatment sector treatment system. The process begins at one of two central intake units (or possibly at a mobile intake site, depending on the individual's needs). The Central Intake Unit conducts a comprehensive screening that matches the individual to the most appropriate initial level of care. The Central Intake Unit also presents the individual with information so that he or she can make an informed choice of a treatment provider.

Individuals are also offered the option of a Recovery Support Coordinator who will support the individual's recovery goals and help him or her access recovery support services that may include childcare, transportation, employment, and housing support.

One of the goals of the position of the treatment liaison is to increase linkages between primary medical care services and specialty addiction treatment services. WIPHL currently achieves these linkages through the position of the treatment liaison. As we look forward to issues of sustainability past the life of our SAMHSA funding, I will continue seeking to create similar learning experiences across the state. Please don't hesitate to contact me if you have ideas about opportunities for creating these vital connections in your area.

April Treatment Update

13 new referrals to treatment (current project total: 228)
8 patients enter treatment (current project total: 81)

Month End Data

March 15–April 14, 2009

Clinics	Eligible for BS*	Completed BS	% BS Completed	Positive BS	% Positive BS	Completed FS	% FS Completed
Amery Regional Medical Center	136	129	94.9%	47	36.4%	40	85.1%
Aurora Family Care Center	119	107	89.9%	46	43.0%	36	78.3%
Aurora Mayfair (0.5 FTE)	208	193	92.8%	36	18.7%	27	75.0%
Aurora Walker's Point	497	478	96.2%	138	28.9%	118	85.5%
Dean - Sun Prairie	399	338	84.7%	103	30.5%	82	79.6%
Family Health/ La Clinica (0.5 FTE)	162	145	89.5%	24	16.6%	22	91.7%
Marshfield - Minocqua Center	333	303	91.0%	61	20.1%	27	44.3%
Marshfield - Park Falls	125	101		34		21	
Menominee Tribal Clinic	130	110	84.6%	36	32.7%	33	91.7%
Milwaukee Health Services, Inc. (0.3 FTE)	40	40	100.0%	16	40.0%	5	31.3%
Scenic Bluffs Community Health Center (0.2 FTE)	25	25	100.0%	5	20.0%	4	80.0%
St. Joseph's Community Health Services - Adults	218	203	93.1%	47	23.2%	53	112.8%
St. Joseph's Community Health Services - Adolescents	25	20	80.0%	5	25.0%	2	40.0%
Upland Hills Health	74	74	100.0%	33	44.6%	33	100.0%
UW Health - Northeast	164	143	87.2%	59	41.3%	49	83.1%
Grand Totals	**2,655**	**2,409**	**90.7%**	**690**	**28.6%**	**552**	**80.0%**

*Eligibility varies by clinic

Data in this and accompanying chart compiled by Jessica Wipperfurth

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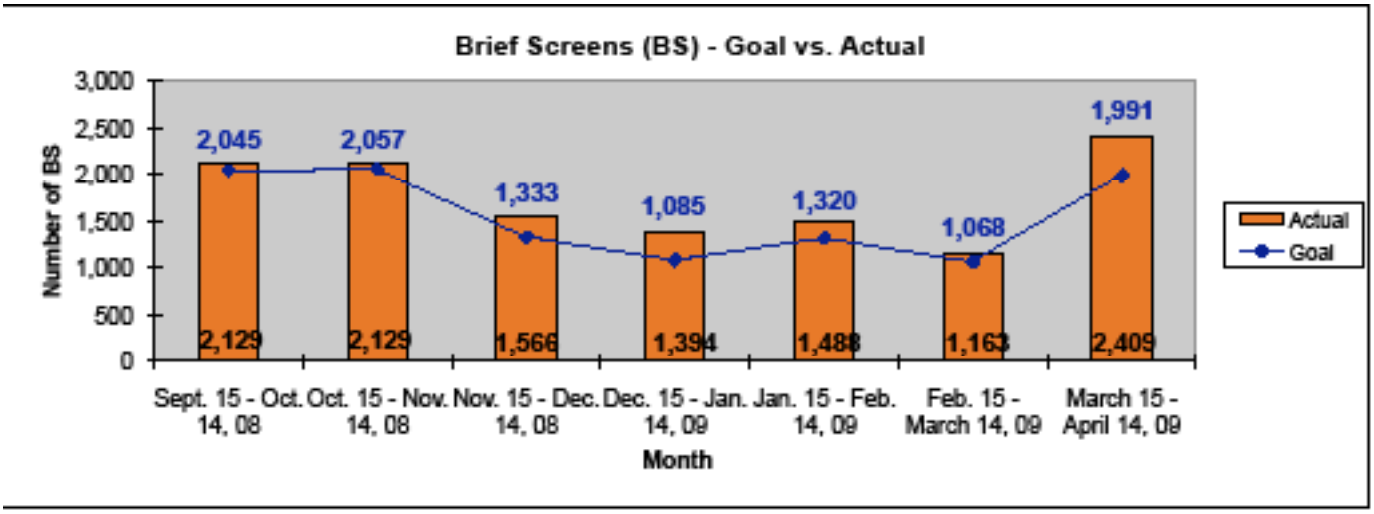
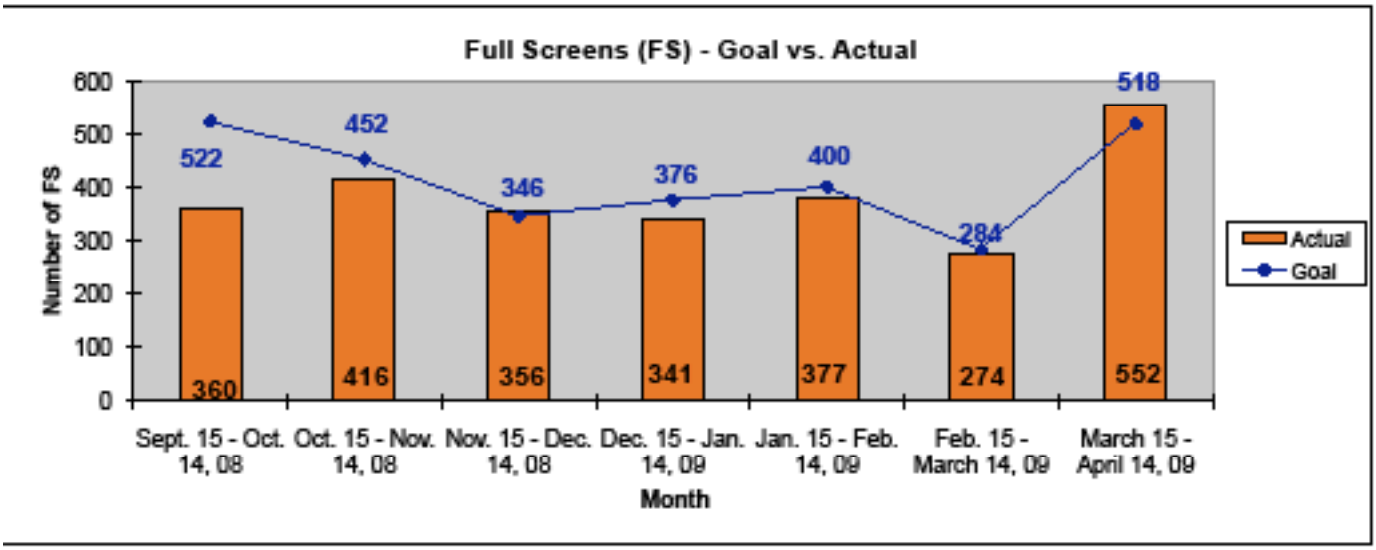
We're on Facebook!

Are you on Facebook? Become a fan of WIPHL (you'll find our page easily by typing "WIPHL" in the search box). If you aren't on Facebook, you can sign up at www.facebook.com. It's a free and fun way to share relevant news and stay in touch with other friends of WIPHL.

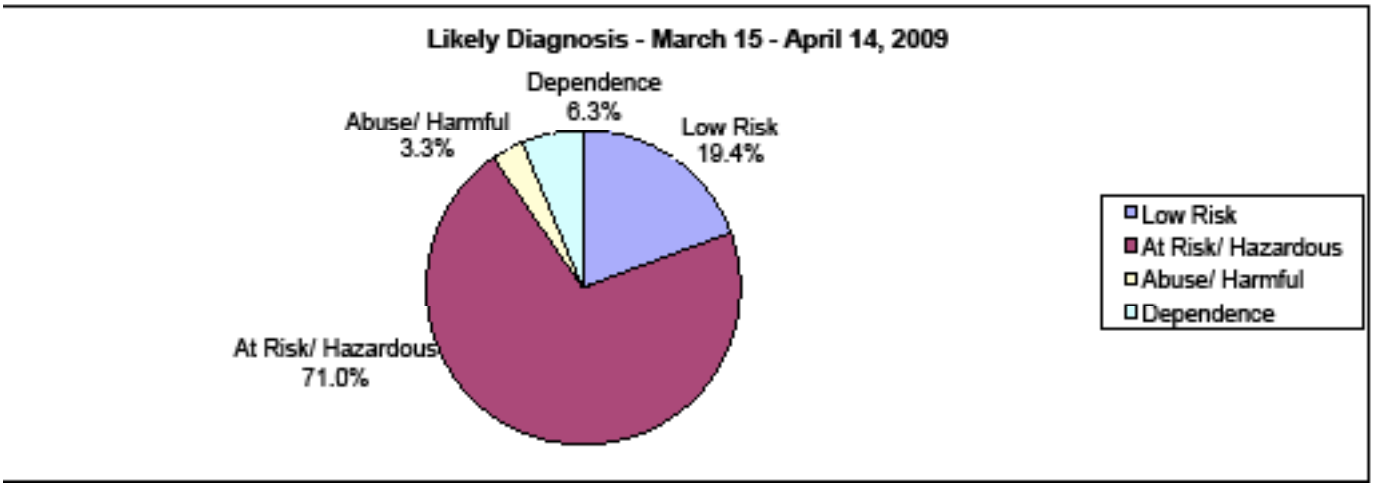
Year-to-Date Data



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



Actual: Number of full screens completed
Goal: Year 3 (March 15 - June 14, 2008) - P4P Clinics: Full screen 75% of patients who brief screen positive
Goal: Year 3 Quarter 3 Goal (March 15 - June 14, 2008) - WIPHL Funded: Full Screen 135 patients per clinic (prorated based upon % FTE)



Calendar

April 22–24
Health educator retreat followed by statewide conference in Tomah

May 6
Governor's Policy Committee Meeting, 1:30-3 p.m.

May 7
WIPHL Speaker Series, WIPHL Tablet Software Demo, 12-1 p.m. More info on page 3.

May 19
WIPHL Speaker Series, Trauma-Informed Services, 12-1 p.m. More info on page 3.

May 27
Cultural Competency Health Educator Meeting, 12-1 p.m.

For other health educator meetings and additional information about events, see www.wiphl.org

The Last Word

Back to a life worth living

From a health educator in southcentral Wisconsin:

The patient, a 40-year-old woman, was hospitalized several times for seizures as a result of her drinking. On the most recent occasion, two months ago, she suffered intense withdrawal symptoms while in the hospital and was put in detox. She was seen by a health educator after being released from the hospital, where she had received no treatment besides detox.

The health educator and treatment liaison Mia Croyle began trying to get her into treatment. She was suffering from severe anxiety and depression at that point; she couldn't even remember talking to them from one day to the next. When they first got her an appointment to enter treatment, she missed it. The WIPHL team got her a second appointment and arranged for a cab to take her to the treatment facility. The WIPHL team also talked to the woman's HR department asking for some time off work, which the patient had been too anxious to do herself.

The 30-day residential treatment was a huge help. "I'm ready to get out and start living my life," she told WIPHL upon her release a few weeks ago. Mia Croyle had arranged for her post-residential care at a center within walking distance from the patient's home, since she does not have a car.

The patient and her husband had recently divorced due in large part to her drinking. She was in such bad shape that the husband had refused to let her spend time with their 16-year-old son, who remains in his father's custody. Now, after treatment and her great improvement in behavior, she has reestablished ties to her son, who knows she was in treatment and fully supports her efforts to remain sober. The patient also has returned to work and attends AA meetings regularly.

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.