The WIPHL Word

Wisconsin Initiative to Promote Healthy Lifestyles

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The Director's Desk

Alcohol Screening/Brief Intervention Ranks No. 4 in Preventive Services

By Richard Brown, MD, MPH
Clinical Director

As WIPHL's primary care partners know, it's quite a challenge to address preventive issues while responding patients' acute concerns and managing their chronic conditions. In fact, a team of researchers calculated that it would take the average primary care clinician nearly 7.5 hours a day just to provide all of the services recommended by the U.S. Preventive Services Task Force (USPSTF), leaving little time to address those other acute and chronic conditions. As most practices are currently configured, primary care clinicians simply can't do it all.

This recognition spawned the development of the National Commission on Prevention Priorities (NCPP), which is funded by the Centers for Disease Control and Prevention and the Agency for Healthcare Research and Quality. NCPP set out to prioritize preventive care that was previously recommended by the USPSTF. The question they sought to answer was: If primary care clinicians don't have the time and resources to administer all recommended prevention services, which services should receive the highest priority?

The answer might be quite a surprise. Alcohol screening and brief intervention was ranked fourth, behind (1) discussing daily aspirin use for men over 40 and women over 40, (2) administering childhood immunizations, and (3) smoking cessation. Alcohol screening and brief intervention was ranked higher than screening and treating hypertension; screening for colon, cervical, and breast cancer; administering adult immunizations for flu, pneumonia, and tetanus; and providing various kinds of dietary counseling.

How was this ranking performed? Researchers computed two statistics for each preventive service. One is the clinically preventable burden. This gets at how much disease, injury, and premature death would be prevented if the service were delivered to all recommended patients.

The other is cost-effectiveness or return on investment—in other words, for each dollar spent on preventive services, how many dollars are ultimately saved? Alcohol screening and intervention scored a 4 out of 5 for clinically preventable burden and a 5 out of 5 for cost-effectiveness.

Interestingly, the rating for alcohol screening and brief intervention was based on an expected 17% rate of success for brief interventions. Just 1 of every 6 patients who receives a brief intervention needs to reduce their drinking to low-risk levels for screening and brief interventions to yield this wonderful pay-off. Cost-effectiveness was calculated assuming that physicians would provide the intervention. To the extent that our health educators can deliver interventions at lower cost than physicians, and to the extent that our health educators can be more effective than physicians because they can spend more time with patients, **the WIPHL model may exceed the NCPP's calculated benefits.**

What does this all mean for WIPHL and for primary care clinics?

• Clinics should make delivery of alcohol screening and brief intervention a high priority. WIPHL can help clinics deliver these services in an evidence-based and efficient manner.

• WIPHL can bolster its utility for patients and clinics by expanding to address additional top 25 prevention concerns, including tobacco cessation, nutrition, and depression. We are moving in this direction.

• Clinics can take advantage of the WIPHL model by freeing up physicians, nurse practitioners, and physician assistants to provide other preventive services that only they can provide.

For more information:

Maciosek MV, Coffield AB, Edwards NM, Flottemesch TJ, Goodman MJ, Solberg LI. Priorities among effective clinical preventive services; results of a systematic review and analysis. *American Journal of Preventive Medicine* 2006; 31:52-61.

Solberg LI, Maciosek MV, Edwards NM. Primary care intervention to reduce alcohol misuse; ranking its health impact and cost-effectiveness. *American Journal of Preventive Medicine* 2008; 34:143-152.

Partnership for Prevention—Go to http://www.prevent.org/content/view/42/70 and click on "Rankings of Preventive Services"

Health Educator Update

WIPHL and MI: Clarifying the Connection

By Laura A. Saunders

As the date for Bill Miller's visit approaches*, I find myself anticipating his arrival like a child anticipates December 25th. Dr. William Miller, for those of you who don't know, is the founder of Motivational Interviewing (MI). At a training I attended last January, Bill told the story of how motivational interviewing came to be. In short, "I made it up," he said. While MI is something Bill "made up," so is psychoanalysis, made up by Freud. Bill's colleagues noticed that he had great success in getting his clients to make behavior changes and started asking him about it. They studied what it was that Bill did naturally and the theory of MI was born. Now decades later, we have tons of theory on MI and we are close to having a science of MI.

As you know, WIPHL health educators use MI with their patients. What I find with MI is that people often have an idea as to what it is—but sometimes with a few misconceptions mixed in. Here are a few simple precepts that help clarify what MI really is.

What is MI?

Motivational interviewing is a client-centered, guiding counseling style for enhancing intrinsic motivation for change by exploring and resolving ambivalence. The work that WIPHL health educators (HEs) do with patients is guided by motivational interviewing. Thus, the following principles apply.

Health educators do not assume an authoritarian role. They do not tell patients how to run their lives.

The term "health educator" may evoke the image of a teacher. Perhaps a better title would be "health guide." HEs give information to patients after they ask patients what they know and ask permission to provide additional information.

Health educators leave the responsibility for change with the patient. Their message is, "It's your choice if, when, and how to change. No one but you can make that choice."

After a detailed assessment, HEs give patients personalized feedback about their likely diagnosis and give a recommendation. The decision to quit, cut down, or do nothing is left totally up to the patient.

WIPHL health educators understand that the motivation for change comes from within the patient; they cannot force someone to be motivated.

This is hard for HEs. It is hard for all helpers. It often seems that we know what's best for patients and that if we could just get them to see it our way, they would come to the light. It doesn't work that way. When we use an authoritarian stance, we will often get a compliant statement: "Sure, I'll try". But if there is no genuine investment in that statement, patients are unlikely to actually comply and are even more likely to be afraid to come back after they have failed to achieve the goal—a goal set by the clinician.

"People possess substantial personal expertise and wisdom regarding themselves, and tend to develop in a positive direction, given the proper conditions and support."

—Miller & Moyers, 2006

Health educators know that the reasons for change come from within the patient. They can help elicit those reasons and encourage the patient to increase the number and importance of those reasons, but they can't force them on the patient.

HEs do this in a number of ways. Part of their protocol includes a systematic review of possible alcohol- and drug-related consequences. Patients are asked whether they have experienced each consequence—and whether it is (or is not) related to their use of alcohol or drugs. After eliciting this information and providing additional information (after asking permission to do so), HEs help patients to see if their reasons for reducing or stopping use outweigh their reasons to continue using.

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WIPHL health educators understand the transtheoretical model of change, which allows them to tailor their interventions to the person.

For example, people who don't realize that their drinking could be contributing to their health problems—or ANY problems for that matter—aren't likely to want a referral to treatment.

WIPHL health educators are empathic helpers whose style is based on warmth, non-judgment, acceptance, and respect.

HEs care about and respect their patients and their patients recognize this. This can be heard in their audiotaped sessions and the overwhelmingly positive feedback we see from the Patient Alliance Questionnaires and the six-month follow-up interviews.

WIPHL health educators are client centered but they are nonetheless in change of the purpose and direction of their sessions with patients.

"Client centered" does not mean that clients control every aspect of the session. Through open-ended questions, reflections, and summaries, they can redirect even the most rambling of patients.

I am especially fond of this metaphor for MI:

> "It's like we are climbing up our own mountain. You are trying to reach the top of yours, and I mine. It turns out that from my mountain I may have a different perspective from yours, so I can help you see things that may not be very clear to you from where you are at. But in the end, you will make the decisions as to how to continue, since it's your own mountain after all and no one can climb it for you."

* For those of you who are unable to attend Bill's conference on March 5th, we will have archived material available on our website.

Register Now for Statewide Meeting!

It's time to register for the WIPHL Biannual Statewide Meeting, April 10-11. We have an exciting two days planned. Dr. John Higgins-Biddle will be giving the keynote at our meeting. He is a nationally renowned expert in Screening, Brief Intervention, and Referral to Treatment (SBIRT), with more than two decades of experience in the field. We also have some terrific workshops and plenary sessions in the lineup, including:

- Best Practices for SBIRT in primary care and public health settings
- Improving linkages between primary care, public health, and AODA treatment providers
- Co-occurring disorders
- Billing and reimbursement for SBIRT
- Promoting demand for SBIRT and working toward sustainability
- Motivational Interviewing

For more information and to register for the WIPHL Biannual Statewide Meeting please go to http://www.wiphl.com/events/index.php?category_id=3460.

If you have any questions, please contact Jessica Wipperfurth at (608) 263-4573, Jessica.Wipperfurth@fammed.wisc.edu.

Cultural Competence Update

Good Reads for Cultural Competence

By Harold Gates

The past month has been filled with numerous activities related to cultural competence. We have started our Governor's Policy Committee subcommittees and they all contain the essence of cultural competence. There are also the beginnings of a committee to explore service delivery barriers for pregnant women. I would encourage you to check out our WIPHL website for an ongoing list of Learning Opportunities, and you are welcome to join our Cultural Competency Committee on our monthly teleconference calls. We have been having some lively dialogue around a number of topics that impact WIPHL service delivery and interesting case studies. At our March 21 meeting (noon-1 p.m.) we will be observing our one-year anniversary and reviewing our progress and setting goals for the next year. We welcome your participation and look forward to another productive year.

This month I would like to share some useful information about new books on cultural competence that would be good additions to your clinic libraries. They are:

Guide to Culturally Competent Health Care, by Larry D. Purnell and Betty J. Paulanka (2005), F.A. Davis Company, Philadelphia

This publication uses the Purnell Model of Cultural Competence, which is useful because it recognizes and includes each client's culture in assessment, health care planning, intervention, and evaluation. The guide serves as a useful tool for assessing the most important aspects of an individual's beliefs as they relate to health promotion and wellness, illness and disease prevention, and health maintenance and restoration. Each chapter is organized by the Model's domains of culturally sensitive care and provides key approaches and interventions highlighted in bold type. The intent is to provide a quick reference for working with selected culturally diverse groups. These approaches and interventions may need to be adapted based on the individual's and family's personal perspectives and circumstances.

Health Literacy in Primary Care: A Clinician's Guide, by Gloria G. Mayer and Michael Villaire (2007), Springer Publishing Company, New York

The authors systematically address numerous aspects of the intersection of practice and health literacy, from creating a patient-friendly environment in the office and hospital setting to health literacy assessment; from understanding and avoiding medical errors to dealing with the interface between culture and health literacy; from improving patient-provider communication to writing and designing effective patient education materials; and from exploring alternative forms of communication to incorporating the use of foreign language interpreters and translators in the clinical encounter. Health care providers can play a crucial role in mitigating the effects of low health literacy if they attempt to educate themselves about the issue.

Substance Abusing Latinos: Current Research on Epidemiology, Prevention, and Treatment, editors Mario R. De La Rosa, Lori K. Holleran, and Shulamith Lala Ashenberg Straussner (2005), The Haworth Press, Inc., Binghampton, NY

The purpose of this volume is to augment the extant literature on the extent and nature of substance abuse among vulnerable Latino subpopulations and increase the knowledge base regarding the role that cultural, familial, and environmental factors have in the development of effective drug interventions for these subpopulations. In this regard the articles included in this special issue focus on providing information on the patterns of substance abuse among Latino gang members, Cuban juvenile offenders, and Puerto Rican homeless women. The volume also includes articles that discuss the role that acculturation factors, parenting skills, availability of insurance, and prior experiences with mental health care and the justice system have on the provision of effective drug prevention and treatment services to vulnerable Latino populations.

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Ethnocultural Factors in Substance Abuse Treatment, editor Shulamith Lala Ashenberg Straussner (2001), The Guilford Press, New York, NY.

While emphasizing the need to see each client as a unique individual, this book demonstrates how clinicians also can take into account the client's ethnocultural beliefs, customs, and values, as well as the social conditions affecting his or her particular group. These variables may provide important information about the client's attitudes toward alcohol and other drugs, patterns of substance use, reasons for seeking treatment, and responsiveness to various interventions. An unusually inclusive range of ethnocultural groups are discussed, encompassing Americans of African, Native American, Latino, European, Middle Eastern, and Asian descent. Addressed in each chapter are such themes as the impact if migration and acculturation issues, spiritual values and traditions, family structures, gender roles, and experiences of prejudice and discrimination. Other topics covered include adolescent treatment and issues related to HIV/AIDS. Chapters also guide clinicians toward greater awareness of the ways their own ethnocultural backgrounds may affect their interactions with clients.

These are but a few of the latest publications that may be useful for us in providing culturally competent services to our patients across the state. I will continue to update you regarding other resources in the future. Please feel free to bring new materials to my attention that you would like to share with other WIPHL cilinics. I would like to thank Rich Brown for sharing the last two books that he picked up at the AMERSA conference in November. As always, you can reach me at Harold.Gates@fammed.wisc.edu or at (608) 265-4032.

Sign Up for March 27 Talk on Multiple Needs and WIPHL

The WIPHL Speaker Series is picking up steam—we had nearly 40 participants from beyond the usual WIPHL circles for our February talk about serving multilingual communities. The series continues with a particularly challenging topic: multiple needs and WIPHL. How may co-occuring disorders present themselves in the clinic, what particular challenges do they pose to the patient, and how can our SBIRT services best address them? We're bringing in three experts from the field. **Dr. Kenneth Kushner** of UW Health–Wingra Family Clinic will talk about depression; **Julie Meyers,** of Western Dairyland Women's Health Center, will talk about sexual health; **Deborah Wubben,** of the UW School of Medicine and Public Health, will talk about diabetes—and, of course, all three speakers will comment on the intersection of these disorders with alcohol and substance use. Bring your questions and be prepared for an enlightening discussion.

When: Thursday, March 27, noon to 1 p.m.

Where: At your desk! (Free teleconference, with PowerPoint slides and other 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.

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

Treatment Liaison Update

Referral to Treatment: Some HE Perspectives

By Mia Croyle

For this month's Treatment Liaison Update, I thought it would be good to hear about the referral to treatment process from a different perspective—that of the health educators. I interviewed Mary Boe, the health educator at Amery Regional Medical Center, and Christina Lightbourn, the health educator at UW Health–Northeast Family Medical Center, about their experiences with referral to treatment.

Mia: Your clinic has experienced great success in the past few months in terms of the number of patients who are willing to accept a referral to treatment in the past few months. To what do you attribute this?

Mary: I believe there has been an increase in knowledge and support of the WIPHL program. Patients are starting to hear about WIPHL not only from me, but from other clinic members. Thank you, ARMC!

Christina: The support of the providers is a huge piece. They do a great job of prepping the patient—sharing their concern about the patient's use and establishing that the clinic is a safe place to talk about it. They present me as someone who will be coming in to talk about different resources (AA, NA, 16 step, referral-to-treatment liaison). In terms of the patients, the degree of consequences they have experienced and their perception of these consequences is the biggest determinant of whether or not they will accept the referral to treatment.

Mia: One of the things I've noticed in talking to your patients is that they seem to have established a good solid connection with you. Tell me about how you are able to connect so well with your patients.

Mary: Having an open ear and listening to the patient is where the trust begins. Also, acknowledging the patient's feeling around the situation is important. I let them know that whether they are excited, scared, nervous, or angry, it is all normal and these feelings are often associated with change. Last, I think that if you use both your head and your heart when meeting with patients you can accomplish a lot. Your head contains the knowledge of the protocol and the resources available to you, and the compassion and caring that all patients need is in your heart. Using both allows the patient to trust that you are there to support and encourage them in all the ways you can. I always make sure my patients know how to get hold of me and that I will always welcome a call from them.

Christina: This sounds cheesy, however—I genuinely like hearing people's stories, and I think they sense this. I also have a background in counseling, and that is helpful, too.

Mia: What one thing about the protocol or your training in Motivational Interviewing (MI) has been most helpful to you?

Mary: Meeting the patient where they are at in the change cycle is number one. I always make sure that my patients know I am not here to judge them or tell them what to do. I am here to listen and help facilitate any change that they desire—desire being the key word because they may need help, but not desire it. What's helpful is always remembering that the change has to come from the patient and to present options in a way that allows the patient to take control of the decisions. We know that change has to come from within, and helping patients feel that power and assurance within themselves is awesome. Affirmations are extremely important as well—I never want my patients to leave a conversation with me when they don't hear me say, "You are worth it!"

Christina: The philosophy of MI is what has been most helpful to me. I like the fact that it is not my job to try and convince someone to enter treatment. My job is to share information with patients, help them look at the pros and cons of their use, and try to develop discrepancy, which is what builds their desire to change.

Mia: What is most difficult or challenging to you about working with patients who want or need a referral to treatment?

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Mary: I think the most difficult thing is the limited availability of actual treatment facilities. It is frustrating when I have a patient who has come to a point where they desire help and feel worth it and there is a delay before that patient can actually get into a treatment facility. I try to collaborate with Mia to provide them with extra support during the "waiting period" while Mia is working on getting them into treatment.

Christina: Motivation is fluid, and that sometimes is challenging. I may meet with a patient who sincerely expresses a desire for treatment and invests a significant amount of time going through the protocols, including the hand off to the treatment liaison, and then something happens and they don't return the treatment liaison's phone calls. It is not unusual for a patient to drop off the map for a few months. What is nice about being at a primary care clinic is that the patient eventually resurfaces, and we have another opportunity to re-engage the patient.

"Motivation is fluid, and that sometimes is challenging. I may meet a patient who expresses a desire for treatment and invests a significant amount of time going through the protocols, and then something happens and they don't return the treatment liaison's phone calls."

Mia: Mary, I know one of the things that has been instrumental in your success has been your ability to connect with patients who have been screened or seen by you at some point and then end up in the hospital for some reason or another. What exists in your clinic system that you are able to stay so informed about your patients?

Mary: Our social worker at the clinic has been very instrumental in keeping me updated on patients who are in the hospital who could benefit from speaking with me. She always discusses with the patient first about whether they would be interested in speaking with me. The social worker also talks with the patient's provider about talking with me. This allows for a streamlined and collaborative continuum of care for the patient.

Mia: Christina, you have a unique system for working with the resources that your clinic already has in place in terms of a referral coordinator. Tell me about what you do at your clinic when a patient has private insurance.

Christina: Whenever a provider makes a referral to another provider (which includes substance abuse treatment), they complete a form that the patient takes up to Loretta Swadley at the referrals desk. Loretta, Northeast's referral coordinator, has been with the clinic over 25 years and is an invaluable resource. After she identifies the patient's funding source (Medicaid, Medicare, private insurance), she identifies what providers are within the patient's network and helps the patient schedule an appointment right then and there. For the WIPHL patients at our clinic who are ready for a referral to treatment, I complete the appropriate portions of the protocols with the patient, refer the patient to Mia, and then take the patient to the referrals desk. where Loretta helps them make an appointment for an assessment. Once that appointment is scheduled, I let Mia know when it is scheduled and she follows up with the patient accordingly.

We thank Mary and Christina for sharing their experiences.

And now, back to my usual report on the numbers. In the month of February, we had:

13 new referrals to the treatment liaison

5 patients enter treatment

The remaining 8 new referrals from February are still actively engaged in the process of seeking treatment.

February 2008
Month End Data

Clinics	Eligible for BS*	Completed BS	% BS Completed	Positive BS	% Positive BS	Completed FS	% FS Completed
Wave 1							
Augusta	92	58	63%	9	16%	4	44%
Eau Claire	278	111	40%	60	54%	29	48%
Northeast	240	172	72%	76	44%	51	67%
Polk County	N/A	64	N/A	33	52%	25	76%
St. Joseph's	310	281	91%	76	27%	69	91%
Wingra	176	70	40%	25	36%	19	*76%*
Totals	*1,096*	*756*		*279*	*37%*	*197*	*71%*
Wave 2							
Amery	N/A	98	N/A	30	31%	18	60%
Clear Lake	N/A	4	N/A	2	50%	2	100%
Luck	N/A	39	N/A	14	36%	5	36%
FamHlt/LaCl. (0.5 FTE)	100	100	100%	28	28%	17	61%
Menominee	182	145	80%	61	42%	30	49%
St. Croix RMC	N/A	22	N/A	9	41%	0	0%
St. Croix Tribal	N/A	2	N/A	1	50%	1	100%
Totals	*282*	*410*		*145*	*35%*	*73*	*50%*
Wave 3							
Mercy Clinic South	412	92	22%	30	33%	15	50%
Sinai Family Care Center	14	14	100%	1	7%	1	100%
Sinai Internal Medicine	18	15	83%	2	13%	0	0%
Walker's Point	285	180	63%	49	27%	25	51%
Waukesha	272	125	46%	38	31%	32	84%
Totals	*1,001*	*426*	*42%*	*120*	*28%*	*73*	*61%*
Wave 4							
Minocqua	199	141	71%	43	30%	20	47%
St. Luke's	128	78	61%	21	27%	17	81%
Totals	*327*	*219*	*67%*	*64*	*29%*	*37*	*58%*
Grand Totals	**2,706**	**1,811**		**608**	*34%*	**380**	*63%*

*Criteria for eligibility varies by clinic

Clinic Corner/QI Commentary

By Lilly Irvin-Vitela

As a project, our QI goals are to successfully establish a system to brief screen 75% of eligible patients at each clinic; successfully establish processes and communication for WIPHL services that maximize opportunities for health educators to connect with patients who self-report risks associated with drinking and/or drug use at least 75% of the time; and do this while successfully delivering the level of health education services each patient needs and is willing to accept. These goals are ambitious. Yet they also are indicators of successfully connecting patients with evidence-based services that have prevention, brief intervention, and referral to treatment components. Many patients can and do benefit from just a single session of health education services, while other patients with greater needs meet with the health educator multiple times, and, if appropriate, are connected with specialty treatment services. A commitment to systematically identify patients who are eligible for services, consistently administer the brief screen to those who are eligible, and support patients in connecting with the health educator are all important and meaningful efforts to improve

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the quality of care patients receive to reduce alcohol and drug risks for patients in primary care settings.

Wave 1 Clinic Highlights

• Lisa Cory provides health education services at UW Eau Claire and the Augusta clinics. In February, both Augusta and Eau Claire were from January to February able to increase the percentage of eligible patients who received the brief screen. At Augusta, for example, there was a 12% increase in patients who received the brief screen. Furthermore, 33 patients were able to complete the full screen and receive a brief intervention to reduce the risks of drinking and drug use.

• Christina Lightbourn and the team at UW Northeast continue to deliver WIPHL services in a coordinated manner. At the site visit, the implementation team discussed the contribution that staff and providers make to the program. Front desk staff members hand out the brief screen to eligible patients and instruct them to return the form to the nursing staff when they are roomed. Nurses review the brief screen and communicate with Christina when a patient screens positive. Christina communicates with nursing staff about the best time to deliver health education services depending on the provider's schedule. Most of the time Christina is able to deliver services prior to the provider entering the room. Christina communicates the outcomes of the health education session to the providers via a written communication in the EMR. In February, Northeast was able to brief screen 72% of eligible patients and deliver WIPHL services to 51 people who self-reported risks associated with their drinking or drug use.

• Terry Murphy continues to work with the team in Polk County and several sites within a site, including Family Planning and WIC. The Polk County team was able to administer the brief screen to 64 patients this month. More than half of the screened patients self-reported some risk associated with their drinking or drug use. Terry completed the full screen and brief intervention with 25 people. In fact, 76% of patients who screened positive on the brief screen received services from Terry in February.

• The three clinics in the St. Joseph's system—Elroy, Wonewoc, and Hillsboro—continue to excel in systematically brief screening patients. The teams at St. Joe's were able to ensure that 91% of eligible patients received the brief screen. Seventy-six patients screened positive and, through a coordinated effort between Sue and her colleagues at St. Joe's, 69 people were able to meet, assess, and explore the impact of drinking and/or drug use in their lives and make positive changes for their well-being. From front desk staff to nurses to medical assistants to providers, the willingness of the whole team to pitch in creates access for patients to much-needed services.

• Julia Yates and the team at UW Wingra are thinking and acting creatively to deliver integrated care. Their approach to WIPHL is indicative of that commitment. At Wingra, Julia and Mary Vasquez time-share the WIPHL HE position. This enables Julia and Mary to address both AODA issues and co-occurring conditions and needs around intimate partner violence and depression. In February, 76% of patients who screened positive on the brief screen received a full screen and brief intervention. Patients also received services to address issues around violence and depression.

Wave 2 Clinic Highlights

• Zella Van Natta and the team at Family Health La Clinica have done it again! They have managed to brief screen 100% of eligible patients. Why is this so significant? This is a meaningful accomplishment because screening for risks associated with drug and alcohol use is something that every eligible patient can expect once a year. Furthermore, both Spanish-speaking and English-speaking patients are systematically receiving these services. By asking all eligible patients and connecting them with services, over 60% of patients who self-reported risky drinking or drug use took advantage of the opportunity to take stock of the impact alcohol and or drugs are having in their lives.

• Mary Boe and the team at Amery Regional Medical Center and the Clear Lake and Luck clinics brief screened 141 patients in February. Forty-six patients who completed the brief screen self-reported some risk associated with drinking/drug use, and Mary was able to deliver services to 25 of those patients—that's 54% of patients. Furthermore, Mary was able to work successfully both with patients who benefited from brief interventions as well as patients who benefited from more extensive services. Her ability to differentiate care based on the level of risk a patient is experiencing is an example of best practices. As implementation efforts continue to progress, more patients will have the opportunity to benefit from WIPHL services.

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• Menominee Tribal Health Clinic and Diane Carlson systematically brief screened 80% of eligible patients. This was an increase from January. The percentage of people that Diane was able to meet with and deliver services to remained consistent from January to February. Thirty patients received services from Diane in February. The Menominee Clinic continues to explore and engage in activities to reduce barriers to services at both the clinic and community level. Their initiative to systematically screen all pregnant women at their first pre-natal visit is commendable.

• St. Croix Regional Medical Center plans to re-launch services this spring.

• The St. Croix Chippewa Tribal Clinic at Hertel was able to serve one patient in February. The implementation team at the tribe in partnership with Polk County is exploring new implementation models to create greater access and engagement in services. This willingness to try new approaches demonstrates a commitment to patient access and leading edge patient care.

Wave 3 Clinic Highlights

• Carrie Buchen and her colleagues at Mercy Clinic South were able to deliver WIPHL services to 15 patients in February. Patients are able to meet face-to-face with Carrie and she is working to develop systems within the clinic to connect with patients who are eligible but have not yet been offered WIPHL health education services.

• Aurora Sinai Family Care Center and Aurora Sinai Internal Medicine plan to re-launch services this spring.

• Aurora Walker's Point is asking more patients about healthy lifestyles. Ten percent more people completed the brief screen in February than in January, and Ruth Perez also was able to deliver more direct patient care. Twenty-five people received health education services for AODA issues in February. Ruth's ability to deliver services in Spanish serves patients at Walker's Point well.

• At Waukesha Family Care Center, Betzaida Silva-Rydz and the team are engaged in a PDSA cycle around improving brief screening participation. Forty-six percent of eligible patients completed the brief screen in February. Of those completing the brief screen, 38 people screened positive and Betsy was able to meet face-to-face with 32 patients. That is 84% of patients who screened positive. From December '07-January '08 the team at Waukesha Family Care Center has made significant gains in connecting patients in need of services with Betsy. Most frequently, nurses and MAs inform Betsy when a patient has screened positive on the brief screen prior to the patient leaving the clinic. This focus on delivering services during the same visit as completion of the positive brief screen and flagging patients who are returning and in need of services is resulting in systematic service delivery. The team efforts are widespread; both those involved in direct patient care and those involved at the front end are part of the success. In fact, during the site visit, Betsy shared an incident in which she received a warm hand-off from a staff member at check-out. The patient had forgotten to turn in the brief screen during the visit and handed it in at check-out. This staff member looked at the brief screen, recognized it was positive, and called Betsy. She was able to deliver services face-to-face with that patient!

Wave 4 Clinic Highlights

• Kerri Weberg and the team at Marshfield Clinic Minocqua Center are consistently delivering brief screens to more than 70% of eligible patients. They also made significant gains in their implementation efforts in February. Kerri was able to complete full screens/brief interventions with over 20% more of the patients who were positive for AODA risks in February than in January.

• Aurora St. Luke's and Wendi Rusch were able to brief screen 61% of eligible patients. Wendi provided a full screen and brief intervention to 81% of patients who brief screened positive, resulting in health education services to 17 people.

WIPHL Calendar

Health Educators Meeting, Waves 2 & 3
March 11, noon – 1 pm

Health Educators Meeting, Wave 4
March 12, 9-10 am

Health Educators Meeting, Wave 1
March 12, noon -1 pm

Health Educators Meeting, Waves 2 & 3
March 18, noon – 1 pm

Health Educators Meeting. Wave 4
March 19, 9-10 am

Health Educators Meeting, Wave 1
March 19, noon -1 pm

Cultural Competency Committee
March 21, noon – 1:30 pm

Health Educators Meeting, Waves 2 & 3
March 25, noon – 1 pm

Health Educators Meeting. Wave 4
March 26, 9-10 am

Health Educators Meeting, Wave 1
March 26, noon -1 pm

WIPHL Speaker Series—
Multiple Needs and WIPHL
March 27, noon -1 pm
(see page 5 for details)

The Last Word

WIPHL is a blessing ...

From a patient who was referred to treatment through the combined efforts of the WIPHL health educator and treatment liaison as well as her insurance company health advocate, who all worked together to coordinate an inpatient admission and ongoing outpatient care:

"This program has been one of God's blessings to me. You have helped me to find ways around all of the barriers that I thought were preventing me from getting well. I've discovered that I was the one creating a lot of those barriers myself in the first place. I'm not all the way healthy yet, and I may never be, but I know I'm better off now than I was before I worked with all of you."

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