The WIPHL Word

Wisconsin Initiative to Promote Healthy Lifestyles

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The Director's Desk

Joint Commission Pushes SBIRT

By Richard L. Brown, MD, MPH
Clinical Director

For the past few years, SBIRT has been on a roll.

The National Business Group on Health and the National Quality Forum endorsed SBIRT. The National Commission on Prevention Priorities disseminated its findings that SBIRT is the fourth most effective and cost-effective preventive service. New billing codes were approved. Medicare began reimbursement in 2008, and increasing numbers of commercial health plans are following suit. The Health Resources and Services Administration inaugurated a requirement that federally qualified health centers track and report their delivery of SBIRT services. Here in Wisconsin, reimbursement for SBIRT for all BadgerCare Plus and Medicaid recipients will begin in January.

The roll continues. On September 1, the Joint Commission—the organization that accredits and certifies more than 16,000 health care organizations and programs in the U.S.—disseminated a proposal that all hospitals provide SBIRT services to all inpatients.

The proposal would establish four new quality measures for hospitals. Three focus on the proportion of appropriate patients who receive screening, intervention, and referral services. The fourth focuses on the proportion of patients who are receiving additional services or reducing their substance use two weeks after discharge. Similar measures were proposed for tobacco.

The proposal makes eminent sense. Many hospitalizations stem from patients' tobacco, alcohol, or drug use. U.S. hospitals lead the world in delivering highly technical, excellent medical care. Of course we should hold them to the same standard in behavioral prevention.

"Rather than dumb down the quality of care to meet payers' reimbursement policies, let's aim to improve reimbursement policies to promote better quality of care."

The proposal comes at a time when payers, such as Medicare, are declining to reimburse hospitals for avoidable readmissions. What better way could there be to prevent readmissions than to help patients adopt healthier lifestyles?

Some hospitals will object because some health plans will not reimburse for these services. I say rather than dumbing down quality of care to meet payers' reimbursement policies, let's aim to improve reimbursement policies to promote better quality of care. It shouldn't be too hard to convince health plan administrators that paying a little more for behavioral prevention during one hospitalization beats paying a lot more for the next one.

The Joint Commission's proposal is open for public comment until September 30. Please express your opinion at: http://www.JointCommission.org/PerformanceMeasurement/WhatsNew.

Rallying Behind SBIRT's Future

More than 700,000 Wisconsin Medicaid recipients will be covered for SBIRT starting in January

By Joan Fischer

In Madison this month, a key group of thought leaders achieved the unthinkable: consensus in health care.

Nearly 100 representatives from all corners of the health care system—including medical professionals, insurance providers and purchasers, legislators, employers, and public agencies—gathered on September 9 for a "special event for thought leaders," as it was billed, convened by WIPHL and the Wisconsin Medical Society.

DHS Secretary Karen Timberlake on SBIRT: "We need to make sure this is literally baked in and made a routine part of the way medical practices operate all across our state."

The meeting's purpose was to inform key stakeholders about SBIRT (screening, brief intervention, and referral to treatment) and provide a forum from which to build concerted support for expanding the program. WIPHL is currently implementing SBIRT at nearly 20 primary care clinics throughout Wisconsin with federal funding that continues until mid-2011.

Numerous studies have shown that SBIRT saves lives and money, mostly by identifying and treating risky drinking and drug use at even the earliest stages of misuse (one such study showed that the program saves $4 for every $1 spent). Savings come largely from decreases in the costly consequences of substance abuse, including ER visits, hospitalizations, car crashes, and criminal justice proceedings.

Cost-effectiveness is a key reason why the state of Wisconsin, despite a huge budget shortfall, in January will extend SBIRT services to all Medicaid/BadgerCare recipients, announced Department of Health Services Secretary Karen Timberlake in the meeting's opening address.

With money so tight, Timberlake said, the state asked, "How can we conserve it, save it, redirect it, push it upstream into more preventive programs? That's really what SBIRT is all about and that's part of the genius of the program."

Extending coverage to all Medicaid recipients means that more than 700,000 Wisconsin residents will be covered for SBIRT services next year, said Timberlake—a dramatic increase from Medicaid's current SBIRT coverage for pregnant women only.

Dean Robert N. Golden, MD: "At the national level, there is more debate and especially more emotion swirling around the issues of health care than I have ever seen during my 30 years in the field. As we try to steer in the most sensible course—and the most effective course—we must remember to use as our rudder evidence-based, cost-effective prevention services."

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Timberlake's announcement drew hearty applause, highlighting that the question of the day was not whether to expand SBIRT, but when and how, especially in the face of limited federal funding.

"You are on the cutting edge of something very, very important," Rep. Jon Richards, one of five legislators in attendance, told the crowd. He suggested four practical measures to advance SBIRT, including removing barriers to training clinicians and requiring a rating system for insurance policies that would inform purchasers whether plans include SBIRT.

The Wisconsin Medical Society's Susan Turney, MD: "This program has a positive economic impact and results in net savings to our health care system and to purchasers and our employers. There is a decreased cost of care, it improves the way we provide the care, and it improves the health of our community."

Timberlake and other speakers—who included Susan Turney, MD, the Wisconsin Medical Society's CEO/EVP; Robert Golden, MD, dean of the UW School of Medicine and Public Health; state Rep. Jon Richards; Dianne Kiehl, exective director, Business Health Care Group; and Lon Blaser, DO, CPE, chief medical officer and medical director of Group Health Cooperative of Eau Claire—emphasized that all stakeholder groups must contribute their time, resources, and efforts to make sustainable SBIRT services a reality in Wisconsin health care.

"This particular program is something that is a win-win-win-win-win across all the domains and across all the collaborators that are at the table," said Dr. Turney.

Participants broke into small groups to discuss barriers to SBIRT implementation and strategies to overcome them. Their suggestions will soon be posted at www.wiphl.org under "Policy/Action."

Anyone interested in learning more about or supporting SBIRT is encouraged to contact WIPHL clinical director Richard L. Brown, MD, MPH, at rlbrown@wisc.edu, tel. (608) 263-9090. You can also visit the initiative's website at www.wiphl.org.

A webcast of the Sept. 9 thought leaders meeting is stored in the Department of Health Services webcast library. See http://media1.wi.gov/dhfs/catalog/ and scroll down to "WIPHL Thought Leaders Meeting."

Cultural Competence Update

Support System Key for Returning Veterans

By Harold Gates

As part of a continuing look at health care needs of returning veterans, I was struck by an article in the Sunday, September 5 edition of the *Wisconsin State Journal*. The article covered the recent suicide of a former Marine who had returned home after two tours of duty in Iraq.

By all appearances, he was doing well according to family and friends, so even they were surprised when he was found dead in his car from carbon monoxicide asphyxiation.

A postcard arrived shortly after his funeral urging him to get a psychological evaluation to assess for suicide, depression, and any other psychological problems. This is a growing problem in the military and it is just now starting to be recognized, with services being developed slowly. There is a renewed urgency based on the fact that 3,300 National Guard members will be returning to Wisconsin after a year of deployment that includes nine months in Iraq. Problems with suicide, depression, and other psychological problems usually don't show up until three to six months after the soldier's return.

The National Guard and other branches of the military have long urged soldiers to get help when they return so that they can recognize signs of depression as well as suicidal tendencies. They can then seek counseling, spiritual guidance, or medication. All of these services are currently available at bases overseas, in the United States, and at VA hospitals. But many returning vets don't take advantage of services due to the stigma attached to mental illness in the military. The paradox is that they don't want to show weakness in a culture that celebrates strength and bravery.

This stigma not only exists in the military but in civilian life as well. Since National Guard units have been deployed multiple times to Iraq and Afghanistan, there can be problems when troops return home. After months of anticipating going home, trouble can arise if a soldier doesn't have a social support network. Those who don't are more at risk for depression and suicidal thoughts. On the next page we are sharing some of the myths and facts about suicide that might be useful as we prepare for the return of our vets and are more informed to assist them and their families as they are screened in our clinics.

There are other relevant military websites that are worth visiting for more in-depth information, conferences, and interactive screening tools. Please take some time to review them and incorporate them into your practice. As always, if you have questions or need cultural competence technical assistance, do not hesitate to e-mail Harold.Gates@fammed.wisc.edu or call (608) 256-4032.

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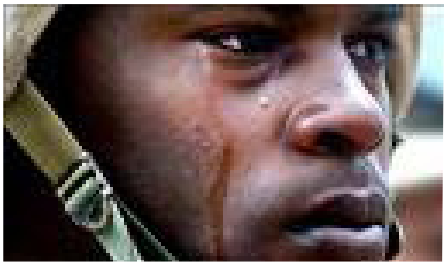

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SUICIDE MYTHS AND FACTS

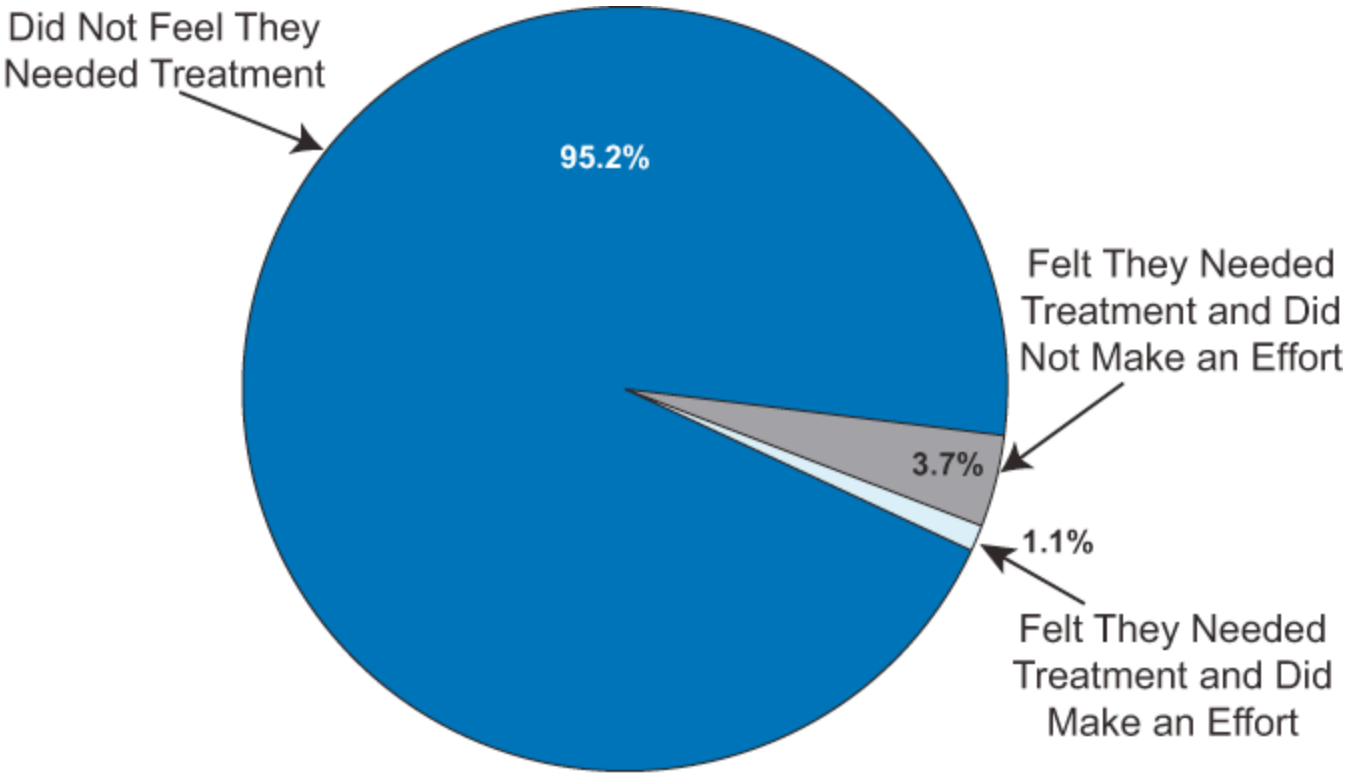
MYTH	RATIONALIZATION	FACT
Most suicides occur with little or no warning.	If you cannot see suicide coming, there is nothing anybody can do.	Most people communicate warning signs of how they are reacting to or feeling about the events that are drawing them toward suicide. These warning signs—or invitations for others to offer help—come in the form of direct statements, physical signs, emotional reactions, or behavioral cues. They telegraph the possibility that suicide might be considered as a means to escape pain, relieve tension, maintain control, or cope with a loss.
You should not talk about suicide with someone who you think might be at risk because you may give that person the idea.	It is best just to avoid it altogether.	Talking about suicide does not create nor increase risk—it reduces the risk. The best way to identify the intention of suicide is to ask directly. Open talk and genuine concern about someone's thoughts of suicide are a source of relief and often among the key elements in preventing the immediate danger of suicide. Avoiding the subject of suicide can actually contribute to suicide. Avoidance leaves the person at risk feeling more alone and perhaps with even less energy to risk finding someone else to be helpful.
People who talk about suicide do not do it.	There is no need to get involved with people who talk about suicide.	People who attempt suicide usually talk about their intentions, directly or indirectly, before they act. Four out of five people who complete suicide talk about it in some way with another person before they die. Failing to take this talk seriously is suspected of being a contributing cause in many deaths by suicide.
Non-fatal acts are only attention-getting behaviors.	These behaviors can either be ignored or punished.	For some people, suicidal behaviors or "gestures" are serious invitations to others to help them live. If help is not forthcoming, there is an all too easy transition between a desperate invitation to receive help and a conclusion that help will never come—between little or no intent to die and a higher intent to die. Punishing suicidal thoughts or actions as if they were an improper way to invite help from others can be very dangerous. Punishment often has the opposite effect to that which is desired. Help with problems, as well as help in finding other ways to ask for that help, is far more likely to be effective in reducing suicidal behaviors.
A suicidal person clearly wants to die.	There is no point in helping. They will just keep trying until they complete suicide.	Most suicidal people are ambivalent about their intentions right up to the point of dying. Very few are absolutely determined or completely decided about ending their life. Most people are open to a helpful intervention, sometimes even a forced one. The vast majority of those who are suicidal find a way to continue living.
Once a person attempts suicide, they will not do it again.	There is no need for concern now; the attempt will be cure enough.	Although it is true that most people who attempt suicide do not go on to kill themselves, many do attempt again. The rate of suicide for those who have attempted before is 50 times higher than that of the general population: 50% of suicide victims have attempted suicide previously.
A suicidal person's need is so great that I cannot possibly make a difference.	They need more than I can provide so only a specialist can help.	There are as many reasons for suicidal behaviors as there are people who engage in them. In terms of finding general rules that apply to all people, suicide is very complex. However, understanding and responding to suicidal behavior in a particular person does not require deep understanding of the motivation or circumstances of the suicidal feelings. All that is required is paying attention to what the person is saying, taking it seriously, offering support, and getting help. Many persons are lost to suicide because this type of emergency first aid and immediate support was not offered or available.

Report Highlights the Need/Treatment Gap

By Mia Croyle

The Substance Abuse and Mental Health Services Administration (SAMHSA) recently released a report titled *Results from the 2008 National Survey on Drug Use and Health: National Findings*. This report presents the first information from the 2008 National Survey on Drug Use and Health (NSDUH), an annual survey sponsored by SAMHSA. The survey is the primary source of information on the use of illicit drugs, alcohol, and tobacco in the civilian, noninstitutionalized population of the United States aged 12 years old or older. The survey does not include homeless persons who do not use shelters, military personnel on active duty, and residents of institutional group quarters, such as jails and hospitals. The survey interviews approximately 67,500 persons each year.

Here are two tables from this report that relate to the topic of patients receiving the necessary treatment:



20.8 Million Needing But Not Receiving Treatment for Illicit Drug or Alcohol Use

Of the 20.8 million persons needing but not receiving treatment for illicit drug or alcohol use in the past year, 95.2 percent did not feel they needed treatment, 3.7 percent felt they needed treatment and did not make an effort to get it, and 1.1 percent felt they needed treatment and made an effort to get it.

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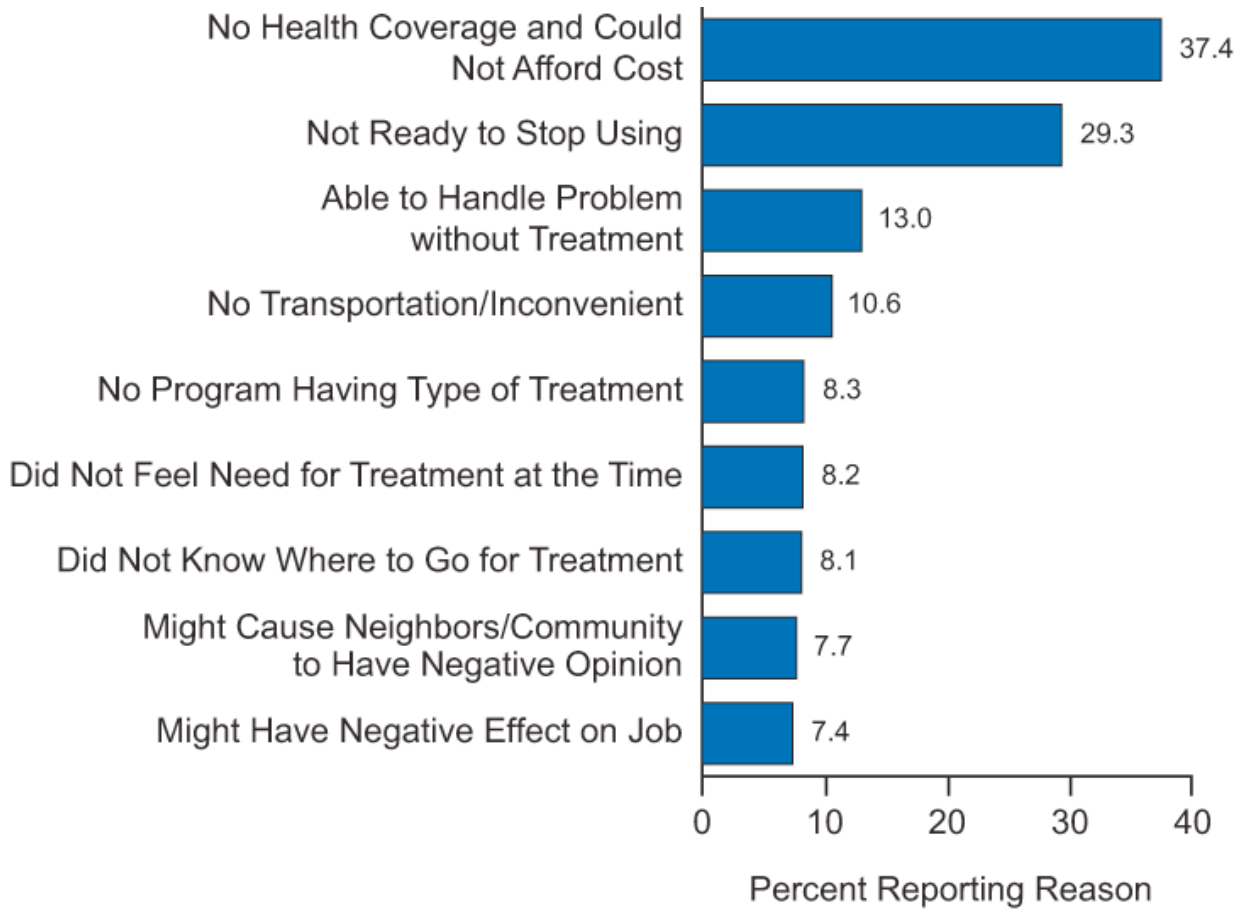
Based on 2005-2008 combined data, among persons aged 12 or older who needed but did not receive illicit drug or alcohol use treatment, felt a need for treatment, and made an effort to receive treatment, the most often reported reasons for not receiving treatment are illustrated in the table below:



The complete report can be found at:
http://www.oas.samhsa.gov/nsduh/2k8nsduh/2k8Results.cfm

Month End Data

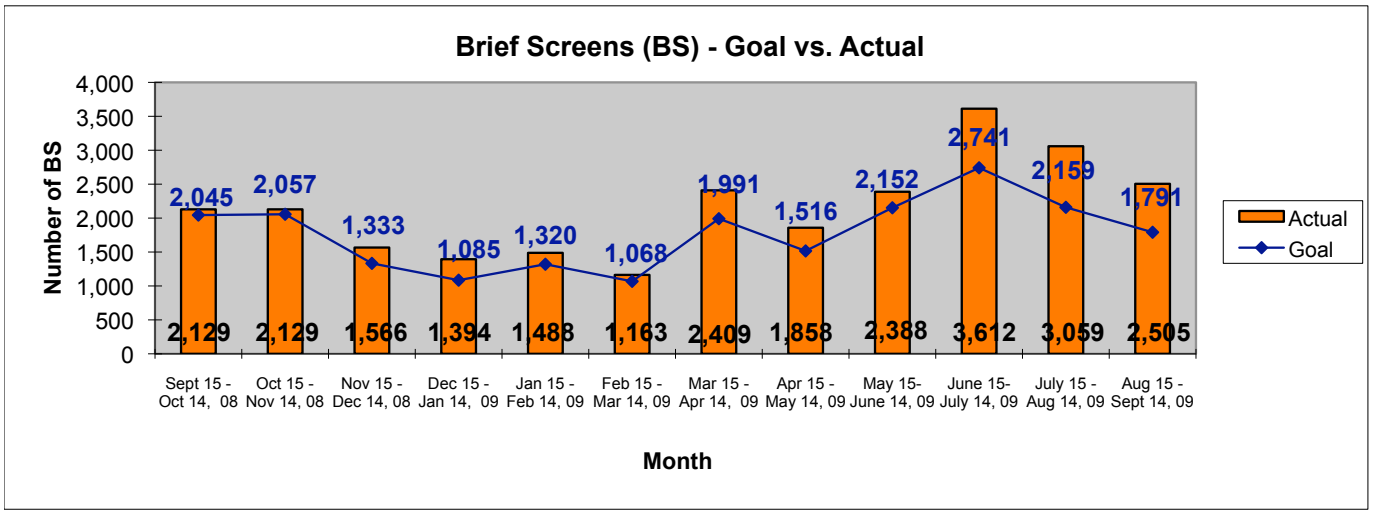
August 15–September 14, 2009

Clinics	*Eligible for BS**	*Completed BS*	*% BS Completed*	*Positive BS*	*% Positive BS*	*Completed FS*	*% FS Completed*
Amery Regional Medical Center	78	73	93.6%	23	31.5%	21	91.3%
Aurora Family Care Center	111	101	91.0%	47	46.5%	43	91.5%
Aurora Sinai Women's Health Center	97	87	89.7%	32	36.8%	37	115.6%
Aurora Walker's Point	226	225	99.6%	73	32.4%	66	90.4%
Beliot Area Community Health Center	385	356	92.5%	102	28.7%	84	82.4%
Columbia St. Mary's	130	119	91.5%	26	21.8%	22	84.6%
Dean - East	263	259	98.5%	85	32.8%	83	97.6%
Family Health/ La Clinica (0.5 FTE)	149	149	100.0%	33	22.1%	29	87.9%
Marshfield - Minocauqa Center	220	197	89.5%	62	31.5%	43	69.4%
Marshfield - Park Falls/Phillips	195	166	85.1%	36	21.7%	28	77.8%
Menominee Tribal Clinic	N/A	282	N/A	72	25.5%	54	75.0%
Milwaukee Health Services, Inc. (0.3 FTE)	11	11	100.0%	6	54.5%	3	50.0%
Scenic Bluff's Community Health Center (0.2 FTE)	23	23	100.0%	5	21.7%	4	80.0%
St. Joseph's Community Health Services - Adults	124	116	93.5%	31	26.7%	41	132.3%
St. Joseph's Community Health Services - Adolescents	15	14	93.3%	1	7.1%	1	N/A
Upland Hills Health	70	69	98.6%	15	21.7%	13	86.7%
UW Health - Northeast	79	66	83.5%	27	40.9%	21	77.8%
Waukesha Family Practice Center	212	192	90.6%	44	22.9%	37	84.1%
Grand Totals	**2,388**	**2,505**	**93.1%**	**720**	**28.7%**	**630**	**87.5%**

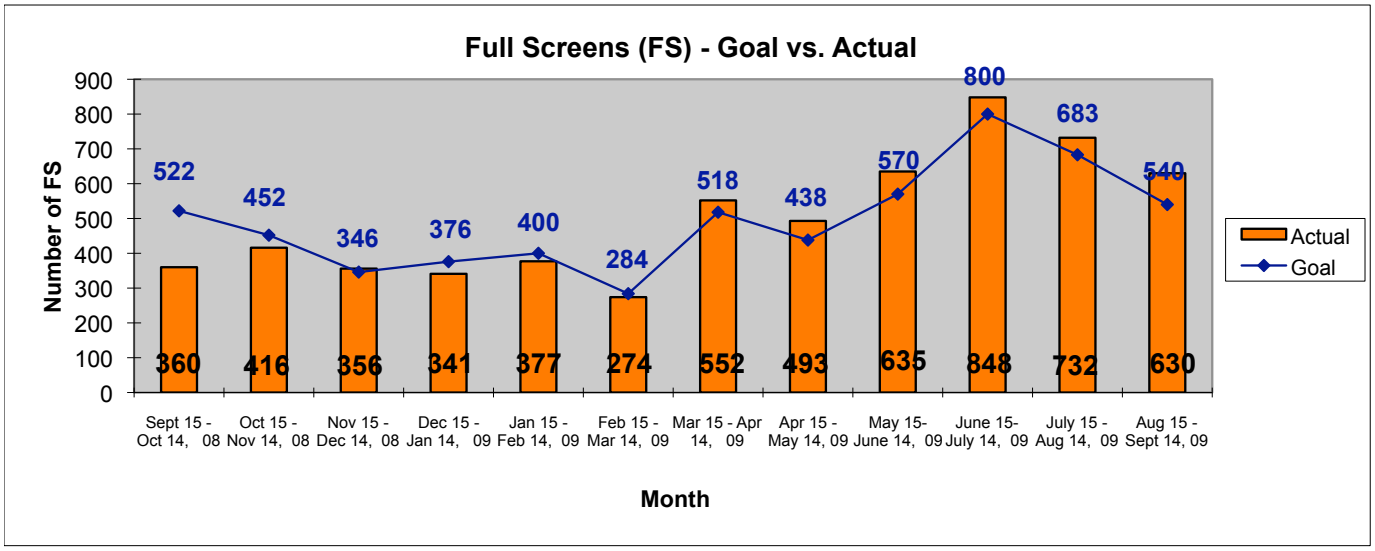
*Eligibility varies by clinic

Data in this chart and charts on next page
compiled by Mia Croyle

Year-to-Date Data



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



Actual: Number of full screens completed
Goal: Year 3 (Sept. 15, 2008 - Sept. 14, 2009) - P4P Clinics: Full screen 75% of patients who brief screen positive
Goal: Year 3 Quarter 2 Goal (Dec. 15 - Mar. 14, 2009) - WIPHL Funded: Full Screen 120 patients per clinic (prorated based upon % FTE)

WIPHL People

We extend a warm welcome to Kim Treml Breidenbach, a medical student at the University of Wisconsin School of Medicine and Public Health. Kim has completed three years of medical school and is now taking a one-year break to pursue a master's degree in public health and spend time with her new baby girl. She will return for the fourth and final year of medical school in July 2010. Kim comes to WIPHL as part of her field experience in the MPH program and is excited to help us expand services into other important health areas such as depression and smoking.

Kim's educational background includes a bachelor's degree in molecular biology from the University of Wisconsin. But more important, her undergraduate experience working with the UW Population Health Institute and the prevention arm of the Comprehensive Cancer Control Program turned her on to the exciting world of health promotion and disease prevention. As a future MD, Kim plans to have a part-time primary care practice and also work part-time with the community she serves to improve health at the population level. She strongly believes that all physicians have a responsibility not only to diagnose and treat the patients they see, but also to address the social, economic, and environmental factors that impact patients' health before they ever arrive in a clinic.

The Last Word

Tracking lasting impact of WIPHL

WIPHL health educators often know when a brief intervention is off to a successful start in terms of changing patient behavior. But do their interventions have lasting impact?

Our evaluation team at the UW Population Health Institute contacts a random sample of patients some five to eight months after the initial full screen and interviews them about their health behaviors. In addition to asking federally mandated GPRA questions, evaluators ask about the patient's interaction with the health educator and whether services provided helped the patient modify his or her lifestyle. So far some 220 patients have been interviewed.

A member of the evaluation team recently shared this story:

"I spoke with a patient today to conduct the six-month follow-up interview. The patient made a lot of changes due to the WIPHL program. The patient went from drinking every single day to drinking two days a week and said that was a huge change. The patient also cut back on smoking and eats healthier. In addition, this patient left an abusive relationship.

"The patient said 'I pick myself up ... I'm going to keep getting better and better.' The patient gave WIPHL a 5, the highest possible ranking."

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 editor Joan Fischer at Joan.Fischer@fammed.wisc.edu.