The WIPHL Word
Wisconsin Initiative to Promote Healthy Lifestyles
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What Makes a WIPHL Clinic Great?

By Candace Peterson, Ph.D.
WIPHL Project Manager

At our statewide meeting earlier this month, the Population Health Institute (UW School of Medicine and Public Health) shared the results of a study asking a simple but very useful question: What makes a great WIPHL clinic great? Or, put more formally, what factors promote or hinder successful implementation of SBIRT in clinical settings?

The immediate results of the study will be used to inform and enhance WIPHL operations in years 4 and 5 of our federal grant. But even more important, they will help us—and possibly other states around the nation—as we formulate best practices for sustainable, universally accessible SBIRT services.

The study, conducted during this past summer, was paid for by our SBIRT grant monies, which are funded by SAMHSA, administered by the Wisconsin Department of Health Services, and coordinated by the Department of Family Medicine (UW School of Medicine and Public Health) and the Wisconsin Medical Society.

Population Health Institute (PHI) staff conducting the evaluation included Douglas Piper, Ph.D., Amanda Lawton Krupp, M.A., Courtney Coen, Robin Lecoanet, J.D., and Janae Goodrich. We thank the PHI staff and participating clinics for this enlightening study.

The Evaluation Questions

- Identify features of clinics which promote success.
- Identify features which are barriers to success.
- Identify changes in processes and influential factors from initial implementation to current operation.
- Eight clinics were chosen for inclusion in the study by evaluators and WIPHL staff.

The Study

PHI conducted a comparative, descriptive study of these eight clinics. A diversity of clinics was chosen using the following criteria:

- Urban, rural, and suburban settings
- Small, medium, and large clinical settings
- Connection or not to a large medical organization
- Longevity of participation in the program
- Program management and operation procedures

The characteristics of clinics participating in the study included:

- Four from rural areas, three urban and one suburban
- Four were connected with a medical school
- One was an independent clinic and hospital
- Three were part of larger medical corporations
- Four were part of the WIPHL program from inception, three joined the program in the last one to two years, and one began implementing the program in the past year

PHI conducted face-to-face interviews with three WIPHL Coordinating Center staff and 28 clinic staff involved in SBIRT, using open-ended questions in an informal, discussion style. Clinic staff interviewed included health educators, clinic champions, clinic managers, medical personnel involved (MD or nurse), and receptionist/ admissions clerk. The interview questions covered topics such as the clinic's decision to participate in WIPHL, the initial implementation of SBIRT, procedures for executing the program during implementation and operation, (e.g., the distribution of brief screens, scoring and tracking of brief screens, and uniting the HE with eligible patients), and key obstacles and facilitating factors.

Once PHI had finished with these interviews, they analyzed the information they had gathered using qualitative methods. The result was a distillation of what is needed for successful SBIRT operations in a clinical setting, from the perspective of those clinical staff who are implementing SBIRT in clinics in Wisconsin. On the following pages, we present a synopsis of the results.

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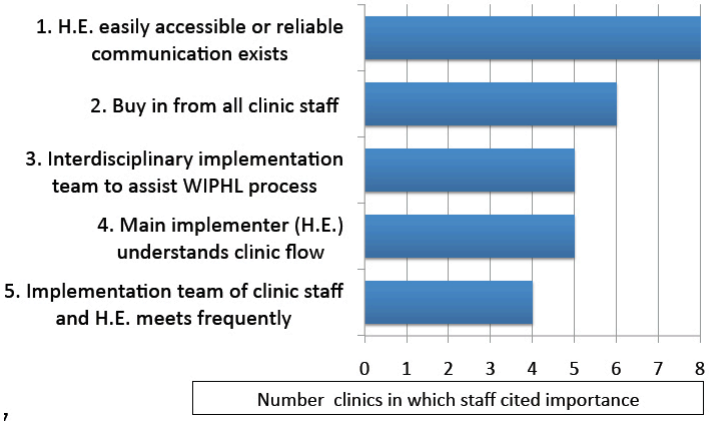
Characteristics of Successful Health Educators

- Engaging personality.
- Proactive, persistent, mission-driven and thick skinned.
- Flexible and adapts to clinic workflow, a team player.
- Self-sufficient and independent.
- Good communicator.
- Quick learner, good at gathering information
- Familiar with the local culture.
- With the clients: compassionate and nonjudgmental, easy to talk to.

Population Health Institute - School of Medicine and Population Health - UW Madison

Clinic Characteristics Conducive to Successful Implementation of WIPHL



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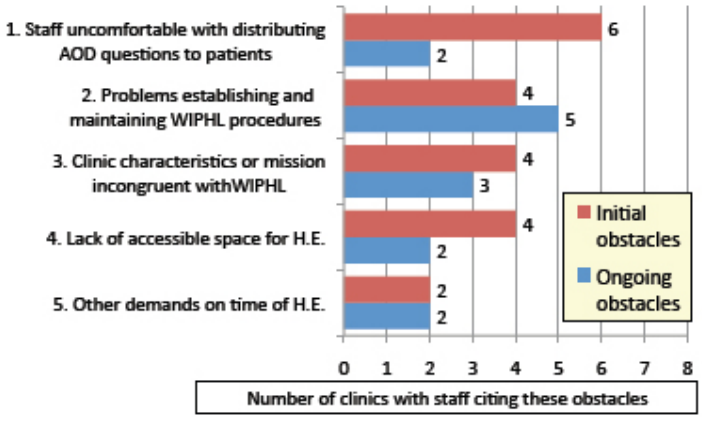
Clinic Characteristics Conducive to Successful Operation of WIPHL

Obstacles to Implementing WIPHL as cited by staff



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Summary – Factors Leading to Success

- Staff buy-in from all areas of the clinic
- An interdisciplinary team of staff working together to facilitate implementation and work through problems.
- Strong program advocate to motivate, lead and monitor other staff
- A Health Educator that is outgoing, organized, proactive, persistent, and fits with clinic culture

Summary – Barriers to Success

- Staff are not comfortable discussing AOD issues or do not believe it should be their role.
- Clinic cannot establish efficient and reliable WIPHL processes
- Lack of buy-in from clinic staff, especially providers and receptionists.
- Lack of clinic recognition that WIPHL needs to involve clinic-wide participation
- Health Educators are not easily accessible

SBIRT Pioneer Visits WIPHL

By Joan Fischer

Attendees of the WIPHL statewide meeting earlier this month had the privilege of hearing from one of the nation's pioneers in alcohol intervention in trauma settings: Larry Gentilello, MD, FACS, professor of surgery, management, policy, and community health at the University of Texas in Dallas.

Colleagues were puzzled when Gentilello, as a resident surgeon, began exploring the usefulness of alcohol interventions in trauma centers back in 1988. But for Gentilello the connection was clear: most of the patients he was performing surgery on were either intoxicated or had collided with someone who was.

"The No. 1 cause of death for people who drink too much is a violent death from a car crash or other type of serious accident," noted Gentilello in his presentation for WIPHL. "No medical specialist sees more patients with an alcohol problem than a trauma surgeon."

When he began his work, trauma centers had little knowledge or training about alcohol problems even though day in and day out they were dealing with the consequences of alcohol abuse, Gentilello said.

Gentilello has done his best to change that. Over the past 20 years he has published more than 90 peer-reviewed articles, textbook chapters, reports, and other materials attesting to the value of screening and intervention for substance misuse in trauma settings. One of his most frequently cited studies, involving trauma patients in emergency rooms, found nearly a 50 percent reduction in recurrent alcohol-related injuries, ER visits, and hospitalizations. For every $1,000 invested in SBIRT services, $4,000 was saved (*Annals of Surgery*, 1999).

If you missed Gentilello's presentation or wish to review it, you can find slides on the WIPHL website (www.wiphl.org) under Events.

Health Educator Update

MI: Good Communication and Good Sense

By Laura Saunders

In an article released last month, "Toward a Theory of Motivational Interviewing,"* Drs. Miller and Rose explore the technical and relational aspects of motivational interviewing (MI).

While there are many ingredients that go into a motivationally adherent intervention, relationship matters the most. Most important was therapist empathy. In one study, differences in empathy predicted two-thirds of the variance in client drinking post-treatment.

In planning for the statewide meeting we held earlier this month, it seemed as if others might be curious about this relational aspect and might benefit from some of this knowledge. While the WIPHL health educators are clearly dedicated to practicing motivational interviewing and use it on a daily basis, we wondered if other WIPHL partners, whether they see patients or not, might be able to use it in other communication.

The goals of the workshop were to:

• Cultivate and/or enhance participants' appreciation for the spirit of motivational interviewing

• Develop understanding of the value and effectiveness of using a motivational approach in communications

• Identify at least one way to incorporate the MI spirit into workplace interactions

To meet these goals we employed discussion, small group work, and videos. Participants were invited to take part in an exercise to strengthen their listening skills.

Comments from participants were favorable:

• Helpful for those who are not health educators.

• Gave good ideas and eye-openers about how to be better at MI. Respect, spirit, strategies. How to be a good listener.

• "Helps me to get the patient's point of view."

• Lots of good techniques and examples. "A chance to stop and learn, to give better care and treatment to my patients."

• The speaker/listener exercise was truly helpful as both speaker and listener; it gave a healthy appreciation of what good listening truly is.

• Good to introduce the philosophy to everyone.

• Great reminders, interactive, great speakers.

The WIPHL Site Operations Team (Mia, Celeste, and I) enjoyed planning and executing this workshop. The possibility that it might contribute to improved communication is icing on the cake!

** Miller, WR and Rose, G. S. (2009) Toward a theory of motivational interviewing. American Psychologist, 64 (6), 527-537.*

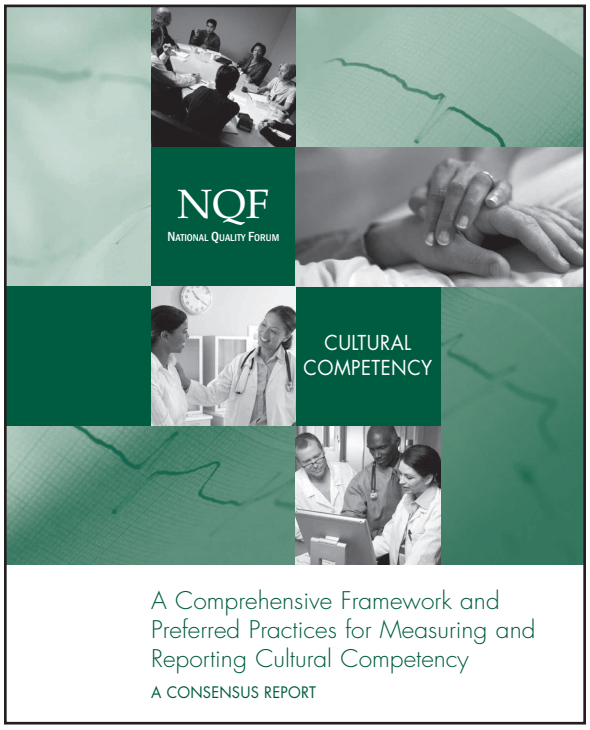
Cultural Competence Update

Tools for Cultural Competence

By Harold Gates

"In order to reduce disparities and improve outcomes, a number of health care organizations are exploring ways to improve cultural competency—that is, to ensure that diverse patient populations receive high-quality care that is safe, patient- and family- centered, evidence-based, and equitable." — John M. Corrigan, Ph.D., MBA
President and CEO, National Quality Forum

The National Quality forum is one of the organizations at the forefront of the cultural competency movement. In April 2009, they introduced a policy brief that explored the ways in which health care organizations could assess where they were in terms of rendering culturally competent services. This document was accompanied by report titled "A Comprehensive Framework and Preferred Practices for Measuring and Reporting Cultural Competency: A Consensus Report." The conceptual frame presented in this report looks at preferred practices and performance measures that cover seven major domains. These domains represent leadership, care delivery, community engagement, and data collection, to name just a few. The complete report and assessment tool can be seen at www.qualityforum.org.



The Joint Commission rolled out a press release in August 2009 indicating it is developing proposed accreditation requirements for hospitals to advance effective communication, cultural competence, and patient-centered care. This 18-month project will increase national attention on cultural competence and quality patient care. The Joint Commission's effort also will result in proposed requirements to advance all of the aforementioned areas. The project commenced in August 2008 and will be completed in January 2010. At the earliest, any implementation of the proposed requirements would occur in January 2011. There is a multidisciplinary advisory panel overseeing the work that includes a local expert, Shiva Bidar-Sielaff, director of community partnerships at UW Hospitals and Clinics. This information can be found at www.jointcommission.org.

Another useful resource is "Multicultural Health Care: A Quality Improvement Guide," located at www.clashealth.org/. This guide is intended for health care organizations that provide or arrange for the care of diverse patients. It is also a resource for organizations that are engaged in quality improvement (QI) initiatives to improve culturally and linguistically appropriate services (CLAS) and to reduce disparities in health care. The interactive website includes ways to assess, organize, implement, and measure efforts.

Finally, the Health Research and Educational Trust (HRET) produced the HRET Disparities Toolkit. This web-based toolkit provides information and resources for systematically collecting race, ethnicity, and primary language data from patients. This instrument could prove invaluable for using data to improve the quality of health care for all patient populations. HRET's Disparities Toolkit can be found at www.hretdisparities.org/.

These organizations and corresponding websites represent the state of the art of the coming together of cultural competence and quality improvement. They can be of use in our efforts as WIPHL moves into Year 4 with its mission of sustainability. If you need cultural competence technical assistance, you can reach me at Harold.Gates@fammed.wisc.edu or (608) 265-4032.

Month End Data

Year 4, Month 1

September 15 – October 14, 2009

Clinics	*Eligible for BS**	*Completed BS*	*% BS Completed*	*Positive BS*	*% Positive BS*	*Completed FS*	*% FS Completed*
Amery Regional Medical Center	131	125	95.4%	51	40.8%	43	84.3%
Aurora Sinai Family Care Center	131	119	90.8%	37	31.1%	30	81.1%
Aurora Sinai Women's Health Center	210	169	80.5%	46	27.2%	45	97.8%
Aurora Walker's Point	224	223	99.6%	74	33.2%	65	87.8%
Beloit Area Community Health Center	322	287	89.1%	89	31.0%	76	85.4%
Columbia St. Mary's	194	176	90.7%	59	33.5%	50	84.7%
Dean – East	207	203	98.1%	70	34.5%	69	98.6%
Family Health/ La Clinica (0.5 FTE)	138	138	100.0%	44	31.9%	36	81.8%
Marshfield - Minocqua Center	208	196	94.2%	46	23.5%	29	63.0%
Marshfield - Park Falls/Phillips	166	133	80.1%	34	25.6%	26	76.5%
Menominee Tribal Clinic	1018	558	54.8%	116	20.8%	70	60.3%
Milwaukee Health Services, Inc. (0.3 FTE)	15	4	26.7%	3	75.0%	3	100.0%
Scenic Bluffs Community Health Center (0.2 FTE)	15	15	100.0%	3	20.0%	1	33.3%
St. Joseph's Community Health Services - Adults	126	122	96.8%	34	27.9%	29	85.3%
St. Joseph's Community Health Services - Adolescents	8	8	100.0%	1	12.5%	0	0.0%
Upland Hills Health	67	67	100.0%	12	17.9%	10	83.3%
UW Health - Northeast	208	175	84.1%	75	42.9%	47	62.7%
Waukesha Family Practice Center	308	279	90.6%	80	28.7%	69	86.3%
Grand Totals	**3,696**	**2,997**	**81.1%**	**874**	**29.2%**	**698**	**79.9%**

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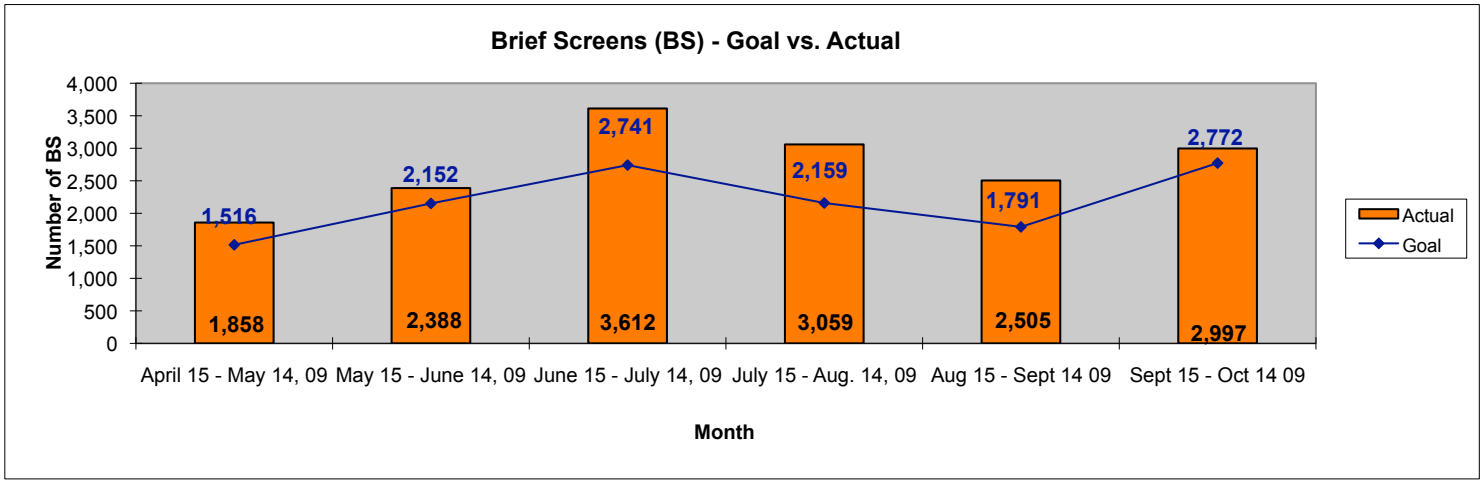
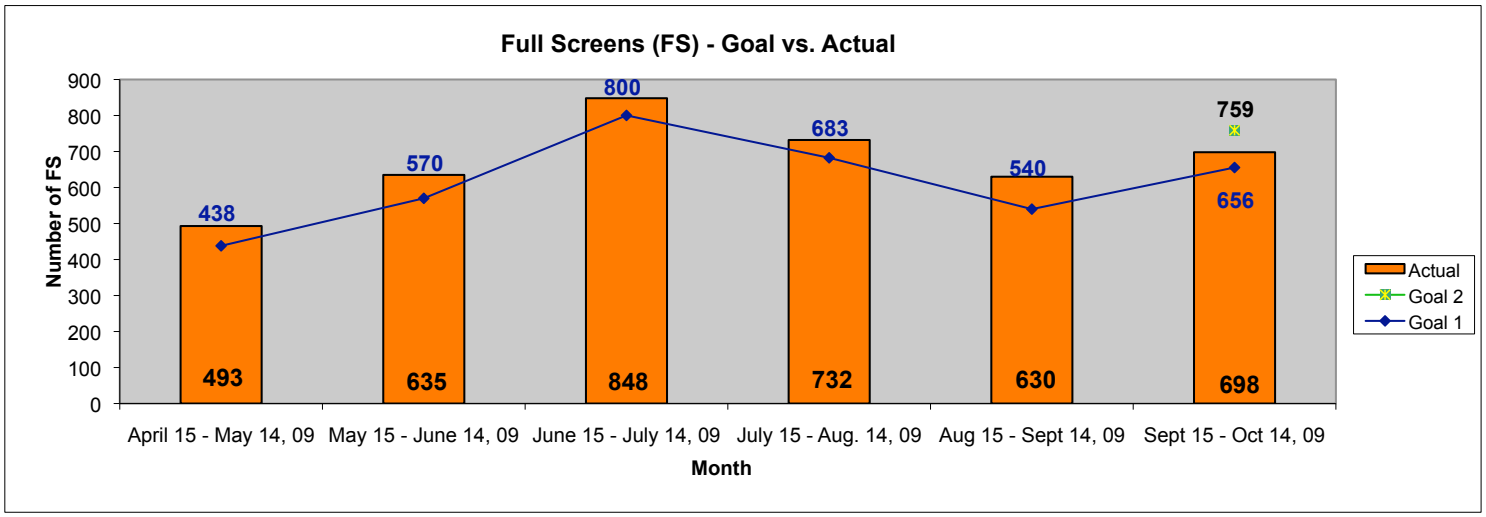


Actual: Number of brief screens completed
Goal: Brief screen 75% of eligible patients



Actual: Number of full screens completed
Goal 1, Year 4 (Sept 15 2009 - Sept 14, 2010): Full screen 75% of patients who brief screen positive
Goal 2, Year 4 Quarter 1 (Sept 15 - Dec 14 2009) - Number varies by clinic based on clinic start date

That Many People Lack Treatment

Ever been to Lambeau Field? Watched a game there on TV? Wow—what an experience! Now picture this …

More than 82,000 Milwaukee County residents need treatment for an addiction to drugs or alcohol but do not receive it. That's enough men and women to fill every seat at Lambeau Field, with nearly 11,000 people left over.

That stunning image comes courtesy of the Milwaukee Addiction Treatment Initiative, a coalition seeking to close the addiction treatment gap. For more facts and figures, and information about what they are doing to find solutions in their community, check out their website at www.ca-ppi.org/solutions/mati/.

Submitted by Mia Croyle, MA, manager of access to SBIRT services.

The Last Word

Nowhere else to go

From a health educator in southeastern Wisconsin

A patient screened positive for drug use. While I was standing outside of the room waiting to see him, the provider came out and told me, "I think he needs your help." Right in the middle of the full screen, the patient, who was only 22, asked, "Can you help me?" Of course I said, "Yes, I can!" He opened up completely, told me all of his fears regarding his use, how it was stopping him from achieving his dreams. He accepted a treatment referral immediately. He told me over and over how grateful he was that there was someone in his own clinic who could help him "get out of this mess," as he put it. He didn't know where to go or who to talk to, so previously he had talked to no one. It's a good thing WIPHL was there.

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.