The WIPHL Word

Wisconsin Initiative to Promote Healthy Lifestyles

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The Director's Desk

WIPHL—Only the Beginning

By Richard Brown, MD, MPH,
WIPHL Project Director

How did five years fly by so quickly!? WIPHL's current SAMHSA, SBIRT grant expires in mid September. Our last patient received grant-supported services on June 30. Some of our health educators have moved on to other jobs, and there are more and more empty desks in WIPHL's central office.

There were so many memorable moments in this project. Early on, there were the huge tasks of writing the grant application and recruiting clinical sites. Then there were even bigger barriers to hurdle in getting the project off the ground, starting to deliver services in six months, and learning how to adapt our initial model to negotiate the real-life challenges of delivering services in busy clinical settings.

But we did it—and "we" includes receptionists, medical assistants, nurses, physician assistants, nurse practitioners, physicians, clinic managers and administrators, billing professionals, and of course, health educators. And "we" includes the many people behind the scenes at SAMHSA; the Wisconsin Department of Health Services; the Wisconsin Medical Society; the UW Department of Family Medicine; the UW Population Health Institute; the UW Medical Foundation; and all of our clinical settings who handled the administrative, financial, legal, logistical, and evaluation aspects of the project. These include the many dedicated people who worked alongside me here in the central office—past and present—whose dedication was instrumental in making WIPHL as good as it could be. Thank you so much to everyone.

That's what WIPHL is all about—systematizing that kind of deeply personal care around important, sensitive issues that often don't get the attention they should in our fragmented, high-tech, rapid-pace healthcare system.

There are undoubtedly more than 1,000 of you who share credit for WIPHL's successes:

- Screening 117,580 patients
- Delivering 26,336 interventions
- Attaining high patient satisfaction
- Decreasing risky drinking by 20%—the same amount as many randomized controlled trials where patients were more self-selected and compensated
- Decreasing depressive symptoms by over 50% in a small pilot study

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Perhaps our largest success is that 11 WIPHL-trained health educators are continuing to deliver SBIRT services in their clinical settings without grant funding. Wow!

WIPHL's numbers are indeed impressive, but for me the numbers take on special meaning, because they are multiplicative indicators of the many patients we touched in very personal ways around the state. Tears often came to my eyes listening to health educators at our statewide meetings talk about their wonderful successes with patients—and reading those "Last Words" of each "WIPHL Word" that described how WIPHL helped one patient at a time. That's what WIPHL is all about—systematizing that kind of deeply personal care around important, sensitive issues that often don't get the attention they should in our fragmented, high-tech, rapid-pace healthcare system.

While our SAMHSA grant—and the regular interaction with so many of you—may be winding down, my spirits are buoyed, because WIPHL continues under funding from the Agency for Healthcare Research and Quality (AHRQ). Please see the article on page 6 for more information. WIPHL is continuing its mission to advance the spread of evidence-based, cost-saving behavioral screening and intervention services.

If you're reading this, you probably had a role in WIPHL's success. You probably share WIPHL's commitment that patients receive behavioral prevention, intervention, and treatment services as excellent as the rest of the healthcare services they receive. Your contributions have formed a solid foundation in Wisconsin for continued expansion of WIPHL's work. I am so pleased that the commitment and contributions of so many of you will live on as WIPHL continues working with clinics around the state to disseminate services that have helped—and will continue to help—so many Wisconsinites. Let's all be very proud. And this is only the beginning.

Access to SBIRT Update

Lessons Learned...

By Mia Croyle, MA and Laura Saunders, MSSW, WIPHL Site Operations

As we wrap things up at the WIPHL central office, the site operations team has been taking stock and reviewing some of the lessons we've learned along the way about implementing SBIRT services and training and supporting health educators. This appraisal will be useful for WIPHL as we transition into working on the Partners for Integrated Care (PIC) initiative funded by the Agency for Healthcare Research and Quality. (See the article on page 6 for more information about PIC).

Time to Prepare Is Crucial: The learning curve for implementing SBIRT was fairly steep. One lesson we learned early on is that the project would have benefitted from more time to prepare for service delivery. This is a balancing act, as there is a certain point when prep time yields diminishing returns. In many cases it would have been especially useful for our clinical sites to have more time to work with us to generate clinic-wide buy-in and understanding of this new service that would be coming to their sites. We also discovered that giving WIPHL Champions "talking points" and instructing them to share information clinic-wide smoothed out some of the bumps in the road when launching service delivery.

It Takes a Whole Clinic: Initially, the WIPHL program was introduced to clinical sites as a "plug-n-play" model where the health educator would complete most, if not all, of the necessary steps in the program. While this was mostly the case in terms of overall workload, we found that most successful implementation occurred at sites where everyone took ownership of the program. Clinic-wide representation is critical in the planning of workflow and the initial implementation so that processes can be put in place that allow for success at every point. Screening and linking of indicated patients to the health educator requires participation from multiple persons at the clinical site. We found that many hands make light work. While the health educator is the one conducting the intervention and the provider gives input and direction as indicated, none of that is possible unless everyone is doing their job getting screens to patients and indicated patients connected with health educators.

Health Educators Benefit From Ongoing Professional Development: Our initial training creates the necessary framework for a health educator to successfully deliver services and creates the potential for continued development and success. After the initial training, we found it immensely useful to provide ongoing support, coaching, and professional development opportunities. In keeping with best practices in adult education, we found that applied information was the most useful to our health educators—for example, rather than just providing a speaker to talk about working with a specific culture, we found it critical to include a facilitated dialogue around how health educators could apply that information to their work delivering SBIRT services. Because this role and these services are still emerging, we found that we often had to create these opportunities for our health educators. When we sent them to outside, more general trainings in the community, we saw fewer instances of the new information being incorporated into existing practices.

Process Helps Health Educator Coaching and Feedback: We started out giving generalized strength-based feedback and having an open discussion with each health educator to review their tape and discuss what they thought went well and what they would like to improve. We experienced modest improvement in Motivational Interviewing (MI) skills using this approach. Eventually, we transitioned to a more concrete, feedback-and-goals-based approach using the Motivational Interviewing Treatment Integrity

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scale (MITI, version 3.1). We saw significant improvement in demonstrated MI skills using this approach. Using the MITI allowed us to provide feedback in a neutral manner and then partner with the health educator to work on areas they chose as focus for improvement. We created a system where the required assessment questions were coded as neutral in the MITI scale, but were still reviewed for accuracy in delivery.

The Beginner Health Educator Sees the Most Acute Cases: Although the vast majority of patients that our health educators see fall into the "at risk" category of use, often in their initial days of service delivery they see a disproportionate amount of likely dependent patients. These are the patients who stick out like a sore thumb at the clinic, and often providers and other staff are eager to have someone on board who can bring a fresh approach to treating patients who often present in crisis or are otherwise thought of as "difficult." This can be a challenge for novice health educators and so we learned to prepare them for this likelihood. And we made ourselves available when health educators started service delivery to field questions and process these encounters with them.

A Local Referral Coordinator Model Yields the Best Results: WIPHL started with a central referral coordinator who offered enhanced case management services focused on treatment entry and continuation. We eventually transitioned to site-based referrals that were coordinated locally with enhanced linkages between general healthcare and specialty services. Having health educators coordinate referrals locally decreased the risk of patients being lost in yet another handoff. It also encouraged the development of ongoing improved communications and linkages between primary care and specialty service providers. Our health educators now receive training on how to locate local resources and work with payers and patients to identify appropriate referrals. There is still a need for occasional technical assistance for especially complex and challenging cases, which we offer centrally.

Performance Measures and Goals Drive Quality: Initially we thought that once we provided clinics with a trained and prepared health educator, we could help them launch services and service delivery volume would follow. We eventually realized that with the high number of competing demands in the healthcare setting, we had to establish service delivery goals and standards to hold sites accountable and give them an incentive to continue to make service delivery a priority. In a sustainable model, national quality measures and the need for revenue from billing to support the health educator salary should replicate the goals and standards we were able to impose as part of our grant-funded initiative.

Cultural Competence Update

Moving Forward with the Cultural Competence Process

Kevin Browne, PhD,
WIPHL Consultant on Cultural Competence

We are approaching the end of WIPHL's five-year grant to support SBIRT services in Wisconsin. For some of us this will mean entering a new phase of work, and can be an appropriate time to look back at our many accomplishments and forward to new opportunities. Cultural competence has been a central part of WIPHL's mission to implement SBIRT services throughout the state. It was incorporated into our mission statement from the beginning, and has been an integral part of all of our health educator trainings, our work with various committees, with participating clinics, and in building community partnerships.

This cultural competence journey has focused on combining cultural knowledge and skills with flexibility and a spirit of inquiry and curiosity. We seek to learn from our patients as we also attempt to help them. It has been exciting and gratifying for me in the past year to work with health educators. I have enjoyed hearing stories of both their challenges and successes as they continually grapple with issues around providing culturally competent services to our diverse patient populations.

It is important to remember this commitment to cultural competence as we move forward. Each of the health educators developed a personal sustainability plan to continue the process of becoming more culturally competent. I am confident that they will all continue to grow in this capacity. So while we cannot say we have arrived at being fully culturally competent, we can always look forward to becoming more so. Whatever directions our health educators and clinics take with regard to providing SBIRT services, we can continue to apply these cultural competence skills and curiosity in a wide range of settings and capacities.

Project Manager Update

WIPHL Transitions to New Grant Promoting BSI in Primary Care

By Jonathan Zarov, WIPHL Director of Communications

This last "WIPHL Word" focuses on the successes of the last five years. But the end is also a beginning. The good work promoting and institutionalizing SBIRT in Wisconsin continues under a new grant, which adds services around depression and smoking cessation.

WIPHL is actively recruiting primary care providers from across the state. Participating clinics will receive training and support. Training for the first wave of participating clinics begins this October.

The work is funded by the agency for Healthcare Research and Quality (AHRQ), which has awarded a $3.5 million grant to a three-state consortium. Named Partners in Care (PIC), together, we'll help up to 90 primary care practices in Wisconsin, Minnesota, and Pennsylvania implement programs.

PIC is creating and promoting a Behavioral Screening and Intervention (BSI) program to address depression and substance use, improving the outcomes of patients who receive depression treatment and reducing high-risk drinking days and drug-use days. Our work is designed to become a model for other states wanting to promote similar services.

WIPHL is collaborating with the Wisconsin Collaborative for Healthcare Quality (WCHQ) at home, the Pittsburgh Regional Health Initiative (PRHI), and the Institute for Clinical Systems Improvement (ICSI) in Minneapolis.

Wisconsin and Minnesota rank second and third in the country, respectively, for prevalence of binge drinking. As mentioned previously, our SBIRT program has helped reduce binge drinking by 20% at participating clinics, which is associated with 20% fewer ER visits, 33% fewer accidental injuries, more than a one-third reduction in hospital admissions, and a 50% reduction in automobile accidents and arrests.

Partners in Integrated Care
Patients, Payors, Providers, Primary Care, Purchasers

The grant's depression work is based on ICSI's DIAMOND program, which has documented a four-fold increase in patients with depression in remission by six months compared to typical primary care treatment.

Look for changes in the next few months as we transition work from one grant to the next. "WIPHL Word" will return this fall as an e-newsletter. Our website will get an overhaul between now and then as well.

We're always interested in your feedback on what kind of information and communications you'd like to get from us. Providers interested in finding out more about the new BSI program are encouraged to contact us. Please contact Jonathan Zarov at *jonathan.zarov@fammed.wisc.edu* or (608) 262-7338.

Month-end data

Year 5, Month 7

May 15, 2011 – June 30, 2011

Clinics	*Eligible for BS**	*Completed BS*	*% BS Completed*	*Positive BS*	*% BS Positive*	*Completed FS*	*% FS Completed*
Beloit Area Community Health Center	118	119	100.8%	30	25.2%	30	100.0%
Family Health/ La Clinica (0.5 FTE)	179	171	95.5%	25	14.6%	12	48.0%
Health Care for the Homeless	242	182	75.2%	48	26.4%	42	87.5%
Northeast Family Medicine	381	286	75.1%	94	32.9%	78	83.0%
Grand Totals	**920**	**758**	**82.4%**	**197**	**26.0%**	**162**	**82.2%**

*Eligibility varies by clinic

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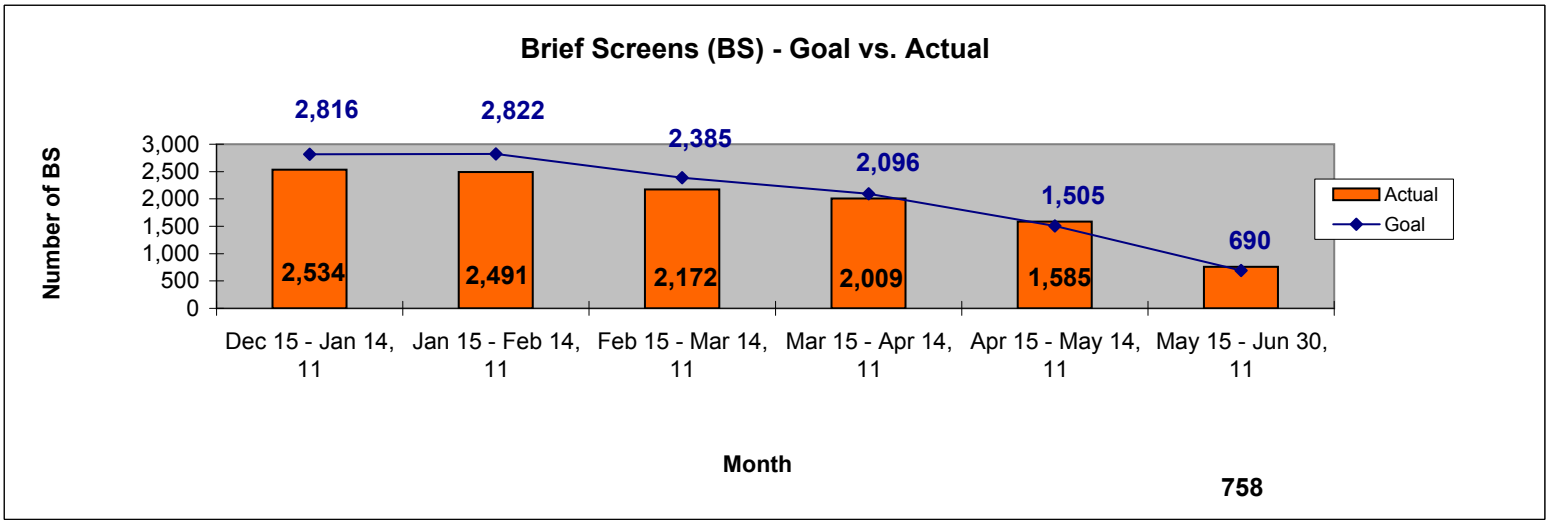
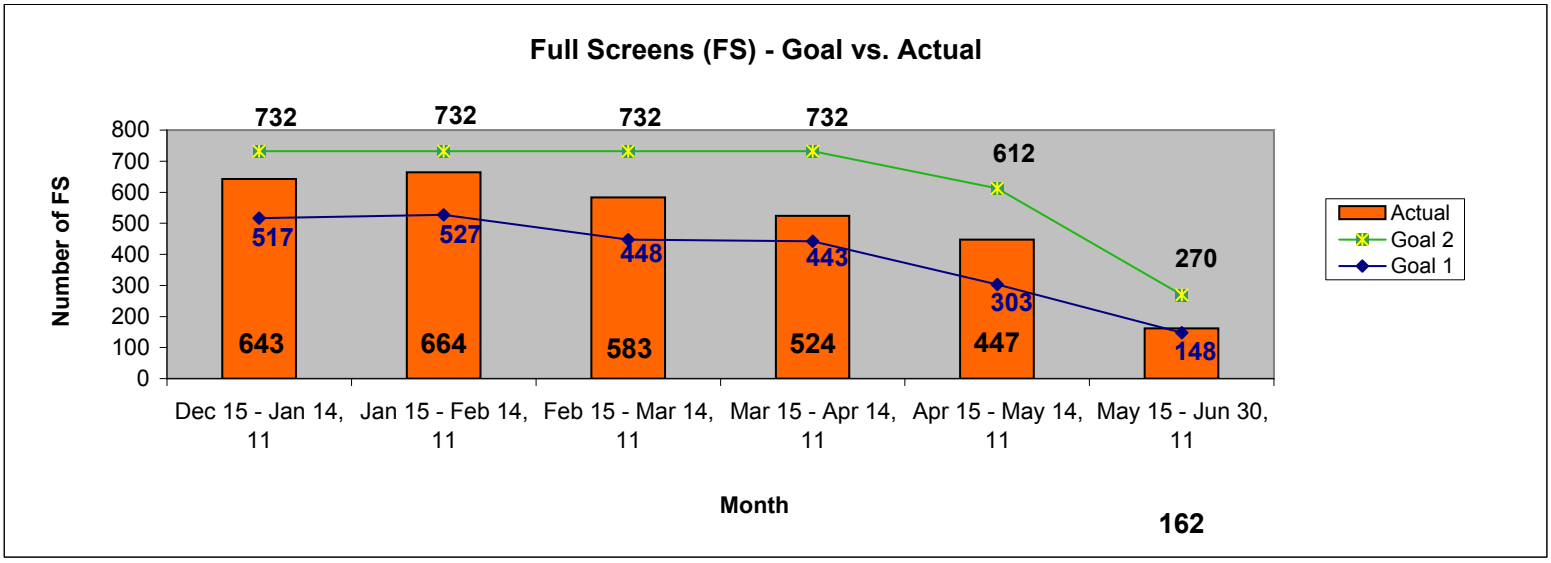
6-month wrap-up



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



Actual: Number of full screens completed
Goal 1: Year 5 (Sept 15, 2010 - June 30, 2011) - Full screen 75% of patients who brief screen positive
Goal 2: Year 5 (Sept 15, 2010 - June 30, 2011) - Number varies by site based on start date

The Last Word

Over the years, we've used this space to share anonymous stories passed along by our health educators. We've delighted in publishing stories of lives improved by changes big and small. Amidst the day-to-day work of systems change, grants management, and policy work, these stories have reminded us of what's at the heart of our labors: guiding patients toward healthier lives. We continue to stand in awe of the dedication of our health educators and the courage and perseverance of the patients with whom they have worked.

Some of you might still have stories that you've not yet passed along—and those who are continuing to deliver SBIRT services are certain to encounter even more. As we continue the work of promoting demand for these services, we encourage you to share these stories with us. Please send to Jonathan Zarov at *jonathan.zarov@fammed.wisc.edu.*

Thank you!

The WIPHL Word 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 our editor, Jonathan Zarov, at jonathan.zarov@fammed.wisc.edu.