The WIPHL Word
Wisconsin Initiative to Promote Healthy Lifestyles
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The Director's Desk

Curtailing Drunk Driving—And More

By Richard L. Brown, MD, MPH
Clinical Director

Wisconsin's drunk driving problem is at long last attracting legislative attention. Most proposals involve strengthening penalties, which is clearly warranted. For example, the first offense is only a violation, not even a misdemeanor! Unfortunately the sharp focus on penalties is hindering consideration of more comprehensive and effective measures.

For stricter penalties to deter drunk driving, potential perpetrators must fear getting caught. For every DWI arrest, there are over 100 episodes of drunk driving that escape detection. With stricter penalties, some people may change their behaviors, but others who have repeatedly driven drunk and not gotten caught are less likely to change. Since 92% of the drunk drivers involved in traffic fatalities have never been caught before, merely increasing penalties will not address much of the problem. Another reason that increasing penalties will be insufficient is that young people, who are the most dangerous drunk drivers, are least likely to fear getting caught, so increasing penalties will be less effective for them.

Imagine a hiker reaching a fork in a trail. One option seems much more scenic and fun, but a "No Trespassing" is posted. However, if there's less than a 1% chance of getting caught, increasing penalties for trespassing will only be marginally effective.

We need to better educate people about what constitutes risky drinking. We define it as five or more drinks for men, and four or more drinks for women—that's often enough to reach .08, and way more than enough to impair one's judgment on one's capacity to drive safely. A critical approach to preventing drunk driving is to reduce drunkenness—to shrink the large pool of people who, when their judgment is impaired by alcohol, may choose to get behind the wheel. Overlooking this approach would be a critical mistake in Wisconsin, as we lead the nation in risky drinking.

There are several proven strategies for reducing risky drinking. One is reducing the demand for alcohol by increasing its price through taxation. Wisconsin's tax on 12 ounces of beer is only six-tenths of a cent—among the lowest in the U.S.—and it hasn't been raised since 1969. Another is strengthening education and enforcement so that bartenders don't serve intoxicated patrons, some of whom drive home. Another is ensuring that Medicaid and private insurers reimburse healthcare settings for providing evidence-based, cost-saving screening, brief intervention, referral, and treatment (SBIRT) services in healthcare settings, as we do at WIPHL.

In addition to making our roads safe, implementing these strategies would help unclog our emergency rooms, unburden our police and courts, decrease healthcare costs and their drag on economic development, reduce child abuse and neglect, and alleviate stresses on county social services systems. And the proceeds from a higher tax could be used to strengthen alcohol prevention, intervention, and treatment programs, which currently are largely inadequate.

Yes, let's tighten penalties for drunk driving. And let's also implement other proven strategies for reducing risky drinking to substantially decrease drunk driving and to enhance health, safety, and well-being throughout our state.

Save the Dates (April 23–24)

Save the dates for our next semiannual statewide conference on Thursday, April 23 and Friday, April 24 in Tomah. This gathering opens at 11 a.m. on April 23 and ends at 2 p.m. on April 24. A health educator training takes place on Wednesday, April 22 and on Thursday morning until the statewide conference opens at 11 a.m.

April 2009 marks roughly the midpoint of WIPHL's five-year grant period. Speakers, presentations, and discussion sessions will focus on the longterm sustainability of WIPHL as well as the particular challenges of providing SBIRT services in rural settings.

Please note that our '08-'09 contract with clinics requires attendance by health educators, clinical/administrative coordinators, and QI coordinators from each clinic. WIPHL will pay for up to four people from each clinic team to attend.

Registration begins on our website in February (we will send an e-mail notification when registration opens). The conference takes place at the Cranberry Country Lodge (very cozy suite accommodations for all).

We look forward to seeing you there!

Greetings from Our New Project Manager

Hello to all of our WIPHL Word readers. My name is Candace Peterson, and I was hired in early November 2008 as the WIPHL project manager. I'd like to introduce myself and explain my job at WIPHL.

My primary duties are to manage the tasks, timelines, and budgets of the WIPHL project, to facilitate institutional arrangements with our partners, and to work on the sustainability of the initiative. My past experience includes work in the substance abuse field since 1990, primarily in prevention, screening, and early intervention. I've served as manager of substance abuse services for Dane County and was a senior program manager and principal investigator at the Pacific Institute for Research and Evaluation, one of the nation's leading independent, nonprofit health research and evaluation organizations. I've also worked on numerous projects as an independent consultant, trainer, and facilitator. I earned a Ph.D. in adult education from the University of Wisconsin-Madison as well as an MS in adult education and an MA in public policy and administration, also at UW-Madison.

I am excited and proud to be part of the WIPHL team and the effort to integrate SBIRT services into health care settings. I have had a chance to meet many of our WIPHL clinic health educators and staff over the last several weeks, and am so impressed by the energy and ability each of them demonstrates. Over the next several months, as I learn more about the project and meet more of our health educators and clinic staff, I will no doubt gain a broader and deeper understanding of the challenges and successes we've seen so far in the project, and the challenges and promises of the future.

Thank you for your interest in and efforts to implement the SBIRT model in Wisconsin. I look forward to getting to know you better and to working more closely with you in 2009.

Treatment Liaison Update

Referral to Treatment: Success in Menominee

By Mia Croyle

The Menominee Tribal Clinic recently celebrated their 50th referral to treatment! This month I would like to examine the factors that have contributed to this impressive number in the hope that we can all learn something from their success.

The Menominee Tribal Clinic has a different referral process than most WIPHL clinics because their system has different treatment resources and challenges.

Health educator Diane Carlson shares some secrets of her success.

The Menominee Tribal Clinic and the Maehnowesekiyah Wellness Center work closely together to provide AODA services to members of the Menominee Tribe. Maehnowesekiyah Wellness Center offers a comprehensive continuum of culturally specific services. This local treatment resource has allowed the clinic to establish a clear referral pathway and direct linkages between primary health care and specialty addiction services.

Another major factor in their success has been health educator Diane Carlson's skill in connecting with patients and helping them increase and maintain their readiness to accept a referral to treatment. I interviewed Diane about her experience with the referral to treatment process.

Mia: Your clinic has experienced great success in terms of referring patients to treatment. To what do you attribute this?

Diane: A large population of this community does not have health insurance or some form of medical assistance. They rely on the Indian Health Services for their health care needs. Each tribe manages these funds somewhat differently. Here on the Menominee Nation there is no tribal funding for AODA issues. WIPHL has been the first program to offer these sorts of treatments to this population. It is much needed and the patients are extremely grateful. Also, our referral system is closed; I make all the referrals while the patient is seated right by me. The patient leaves knowing exactly when they have to report for the treatment process to begin. I have a great working relationship with our treatment center and they do their best to get the patients I refer in as soon as possible. Trust is a huge issue with our patient population, and all the steps of treatment are done in person by folks they know and trust. Word of mouth is the best way for news to travel in this community. The word is out that the clinic helps people get into treatment. Often I hear, "I got your name from X, you helped him/her get into treatment."

Mia: What aspects of the protocol or your training in Motivational Interviewing (MI) have been most helpful to you in getting patients to the point where they are willing to accept a referral to treatment?

Diane: No patient is ever told they need treatment, it is always their choice. They are in control and that alone helps the whole referral process. Often patients will tell me they do not feel they need treatment. They are always told respectfully that it is okay, they alone are in charge. I have found that even if they do not initially accept a referral, a huge seed has been planted. They are thinking about it, and often the next time a negative consequence happens they think about it some more. I have many patients who initially turned down a referral to treatment call me back and say they think they are ready. If patients are somewhat reluctant about a referral, we will talk about other benefits of entering treatment. Treatment at Maehnowesekiyah is not only to get sober; there are many other programs to educate patients about physical, social, emotional, and spiritual wellness. Essentially they help patients see themselves in a whole new way—a better, healthier way that includes sobriety. Finally, if the patient is still reluctant, I encourage them to at least have the assessment and see what treatment choices would be available to them. I tell them that the best way to make an educated decision is to have all the facts and decide from there. Often after just going into the treatment center and seeing that it is a pleasant place, they will reconsider.

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

Diane: The majority of our patients have lived in generational poverty and many have experienced many generations of alcohol and drug abuse. In many populations that survive in poverty, substance abuse is not the true problem, but a symptom of a much bigger problem. Substance abuse has hurt nearly all families in this small community. Even though I honestly believe that sobriety will help the patients and make their lives much better, it is only one aspect of their lives. That said, substance abuse is such a big part of daily life that many patients who choose sobriety have to make a whole new circle of friends and often must also avoid family members. There is not a lot of support for those who choose a healthier lifestyle. I often get discouraged because folks try to make healthy changes and they have no support network. There have been patients who have told me that I was the only person who believed in them and supported them. Even though I am happy they feel they can look to me for support, it makes me sad to think they are fighting this difficult battle nearly alone.

(end of interview)

In December, we had:

13 new referrals to treatment (current project total: 193)

0 patients enter treatment (current project total: 67)

Health Educator Update

Moving Toward Positive Changes in '09

By Laura A. Saunders

December brought a natural slowing down period. Clinics saw fewer patients and the WIPHL HEs were able to take a deserved break. After the rest, we are all back to work.

The WIPHL HEs and I took stock of a number of things and have made some positive changes. We revisited the individual call schedule to assure that the day and time work best. While rescheduling is always inevitable, the new schedule allowed everyone to choose a time that is most likely to be a good time to talk. Because the HEs are also required to have a tape submitted prior to the call, having the call schedule predetermined out to July assists them with planning.

We also revisited the group call format. There were a few suggestions for change although many of the HEs noted that they appreciate the weekly celebration of their accomplishments, the WIPHL health educator "wows." They also appreciate being able to attend any of the three weekly calls. A favorite feature of the calls is the sharing of cases.

Surely there will be many, many cases to share and celebrate in the new year!

REMINDER

Health Educator Retreat

The health educators will be at the WIPHL Coordinating Center on Thursday, January 29 and Friday, January 30.

Cultural Competence Update

New Year, New Work Plan

By Harold Gates

This month brings a flurry of activity on the cultural competence front. January 16 was our first quarterly cultural competency committee meeting of the new year. I invite you to share your ideas about what we might want to consider in our 2009 Cultural Competence Work Plan (printed on the following two pages). We are once again looking at the four main target areas: 1) Service Delivery; 2) Staff/Team Development; 3) Organizational Environment; and 4) Community Relationships. We will review our accomplishments relative to last year's work plan and plan on discussing new ones at our next quarterly meeting on April 17.

At the upcoming health educators' retreat, we will roll out the California Brief Multicultural Competency Scale (CBMCS). This training and assessment tool will be presented on January 30. The purpose of introducing this innovative program is to continue to move our cultural competency efforts to the "next level."

By way of background, the CBMCS started out in 1999 as a tool to briefly administer and assess community mental health practitioners' multicultural training needs. It soon developed into a training manual that looks at four areas/modules. Those modules are as follow: 1) Multicultural Knowledge; 2) Awareness of Cultural Barriers; 3) Sensitivity and Responsiveness to Consumer; and 4) Sociocultural Diversities. All of these modules relate to previous training the health educators have experienced either here at WIPHL or in their own continuing education. The 21-item CBMCS will be sent out prior to the HE retreat to be completed prior to the presentation. This information or "pre-test" will provide the basis for our work and future training on cultural competence and WIPHL.

I encourage you to attend our upcoming cultural competency meeting and/or send me your thoughts on what should be included in next year's work plan. I am also available to discuss the CBMCS with you if you need more information about this exciting venture. Please feel free to contact me at Harold.Gates@fammed.wisc.edu or at (608) 265-4032.

Finally, as we all know, we witnessed some historic events this month. Dr. Martin Luther King's 80th birthday celebration took place on January 19, and the next day President-elect Barack Obama was inaugurated as our nation's 44th president. Please take some time to reflect upon the significance of these remarkable events in our lives.

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Sign Up Now for February 24 Talk on Prescription Drug Misuse

The *WIPHL Speaker Series* continues with a talk about a rising trend in the addiction field—misuse of prescription drugs. WIPHL clinical director Richard L. Brown, MD, MPH will discuss how medical and counseling professionals can best help these patients.

When: Tuesday, February 24, 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.

Cultural Competency Committee
Draft Workplan 2009

Goal- Decrease disparities in AODA health outcomes for patients in WIPHL clinics

SERVICE DELIVERY	Priority	Actions	Resources	Review	Completed	Outcome	Evaluation	Responsible Person
Training on how to better serve the elderly population								
Health messages are at a very high literacy level and need to be simplified and also gender and culturally competent								

STAFF/TEAM DEVELOPMENT	Priority	Actions	Resources	Review	Completed	Outcome	Evaluation	Responsible Person
Have a toolkit or resources to help HE's work better with different populations								
More training on the corrections system and have more of an understanding on probation and parole								
Address Stigmas staff and patients have about drug and alcohol use.								
More information on prescription drug abuse								
Address stigmas and stereotypes on who is abusing substances								

Cultural Competency Committee
Draft Workplan 2009

ORGANIZATIONAL ENVIRONMENT	Priority	Actions	Resources	Review	Completed	Outcome	Evaluation	Responsible Person
Having clearer policies especially policies on corrections								
Look at the screening qualifications for each clinic as well as the patient population to see if we should be adding more or reducing the qualifications to reach as many patients as possible								
Training or simulation on how to use the language line in order to eliminate the patients family or friends doing the translation								

COMMUNITY RELATIONSHIPS	Priority	ACTIONS	Resources	Review	Completed	Outcome	Evaluation	Responsible Person
Public relations materials should be translated into other languages								
Reach out to other groups of other communities								

Month End Data

December 15, 2008—January 14, 2009

Clinics	Eligible for BS*	Completed BS	% BS Completed	Positive BS	% Positive BS	Completed FS	% FS Completed
Wave 1							
Northeast	228	195	86%	94	48%	54	57%
Polk County	67	66	99%	28	42%	21	75%
St. Joseph's	217	210	97%	49	23%	31	63%
Totals	*512*	*471*	*92%*	*171*	*36%*	*106*	*62%*
Wave 2							
Amery	103	95	92%	37	39%	20	54%
FamHlt/LaCl. (0.5 FTE)	97	97	100%	36	37%	36	100%
Menominee	182	118	65%	49	42%	44	90%
Totals	*382*	*310*	*81%*	*122*	*39%*	*100*	*82%*
Wave 3							
Mercy Clinic South	145	104	72%	33	32%	11	33%
Waukesha	218	97	44%	35	36%	26	74%
Totals	*363*	*201*	*55%*	*68*	*34%*	*37*	*54%*
Wave 4							
Minocqua	122	101	83%	24	24%	10	42%
St. Luke's	144	108	75%	28	26%	24	86%
Totals	*266*	*209*	*79%*	*52*	*25%*	*34*	*65%*
Wave 5							
Family Care Center	103	91	88%	45	49%	35	78%
Mayfair (0.5 FTE)	143	115	80%	32	28%	7	22%
Milwaukee Health Services (0.3 FTE)	43	27	63%	7	26%	2	29%
Scenic Bluffs (0.2 FTE)	23	23	100%	4	17%	4	100%
St Croix Tribal Clinic (0.5 FTE)	24	N/A	N/A	N/A	N/A	16	N/A
Totals	*336*	*256*	*76%*	*88*	*34%*	*64*	*73%*
Grand Totals	**1,859**	**1,447**	***78%***	**501**	***35%***	**341**	***68%***

*Eligibility varies by clinic

Data in this and accompanying charts compiled by Jessica Wipperfurth

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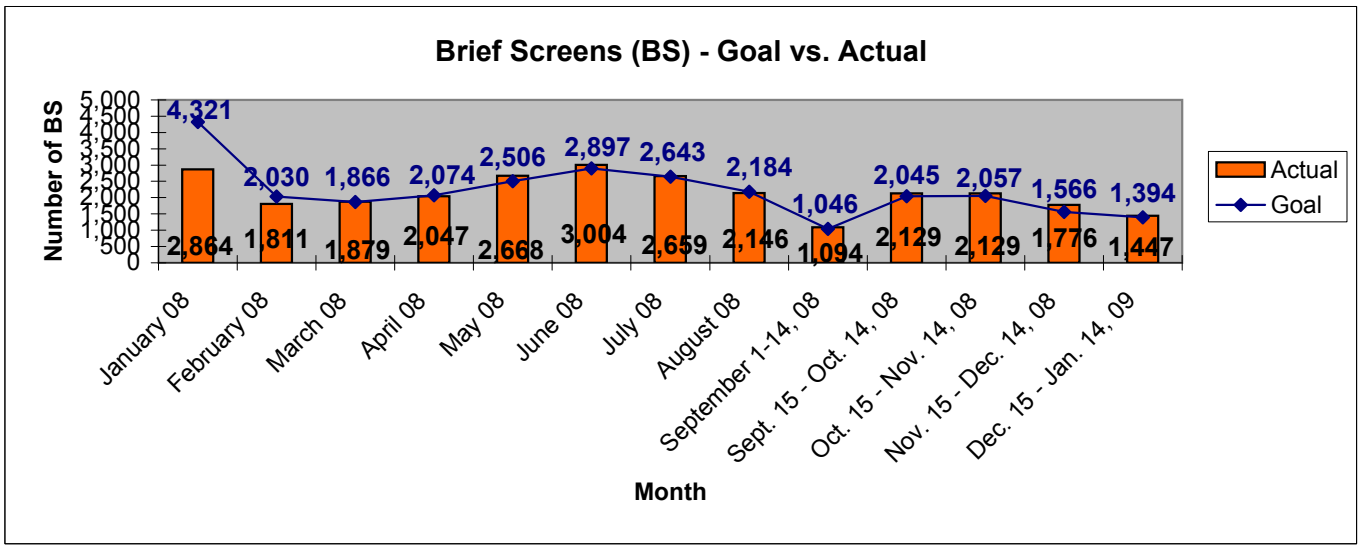
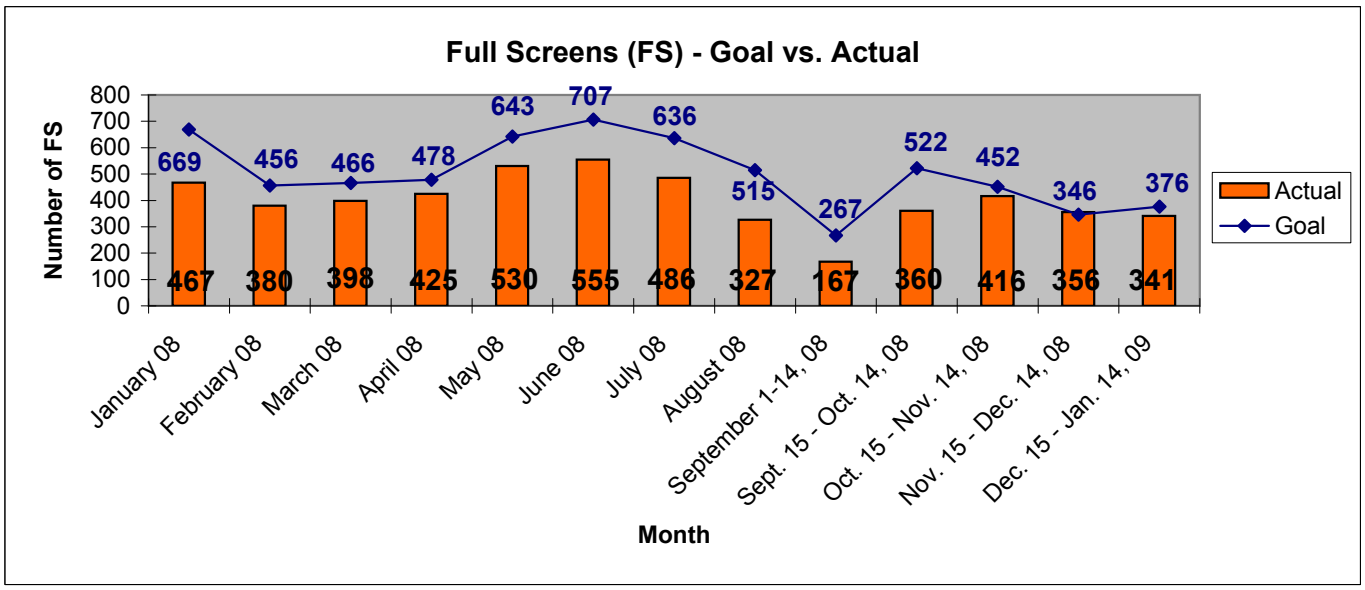
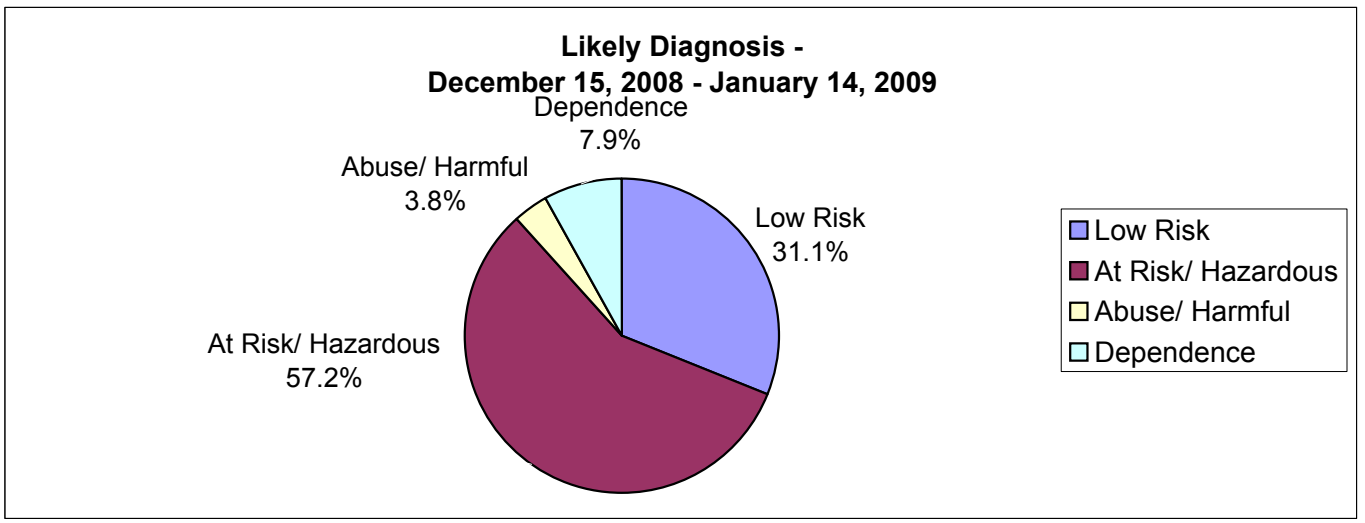
Year-to-Date Data



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)



Calendar

Jan. 29–Jan. 30
Health Educator Retreat

Feb. 9
Governor's Policy Subcommittee Meeting, Promoting Demand, 1–2 p.m.

Feb. 24
WIPHL Speaker Series: Dr. Richard L. Brown on prescription drug misuse, free teleconference 12-1 p.m.
(See page 5 for registration info)

For other Health Educator meetings and additional information about events, see www.wiphl.org

The Last Word

RN Gets a Wake-Up Call

From a clinic in southeastern Wisconsin

The patient, a man in his 40s, had been a registered nurse for more than 25 years. He was given the full screen after scoring positive on his brief screen for having six glasses of wine on New Year's Eve. He was shown the alcohol limits recommended by WIPHL and the National Institute on Alcohol Abuse and Alcoholism and listened politely to all I had to say. But he then went on at length about how he was in control of his drinking, he knew what he was doing, everything was okay.

The problem is that even drinking that much on only one occasion puts a person at risk for negative health, social, and legal consequences. It is sometimes hard for people to understand that even one time is too much.

However, I felt this was a successful intervention, because as we were leaving the room—after he had made his lengthy arguments and I was sure my information had not made an impact on him—he turned to me and said, "You know, I guess that really was too much for me to drink."

The way he said it, I knew I'd gotten through to him.

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