

WIPHL Thought Leaders Gathering  
 Sept. 9, 2009

Summaries of Group Discussions

**Table 1**

Barriers	Strategies
<ul style="list-style-type: none"> <li>• Special commercial interests (Tavern League)</li> <li>• Sustaining momentum for SBIRT</li> <li>• Stigma associated with AODA (public perception=use is a choice)</li> <li>• Regulations and budget requirements (e.g. ERISA)</li> <li>• Limited flexibility in settings</li> <li>• Financial support in economic scarcity</li> </ul>	<ul style="list-style-type: none"> <li>• HW 2020</li> <li>• Ensure SBIRT support in payor mix (universal reimbursement)</li> <li>• Leadership from state</li> <li>• Emphasize evidence and ROI</li> <li>• Actuarial analysis</li> <li>• Mandates on insurance/payors</li> <li>• HE workforce: retired health care professionals</li> <li>• University/secondary education public health (e.g. integrate SBIRT in undergrad curriculum in public health)</li> <li>• Tax credits</li> </ul>

**Table 2**

Barriers	Strategies
<ul style="list-style-type: none"> <li>• Work flow in <u>busy</u> practice</li> <li>• Patient expectations (not purpose of visit)</li> <li>• Space limitations</li> <li>• Billing for telephone interventions</li> <li>• Multiple diagnoses</li> <li>• How to do billing</li> <li>• Clinician doubts and worries</li> </ul>	<ul style="list-style-type: none"> <li>• Physicians set the stage for health educator intervention</li> <li>• Flexible intervention. Something gets said to the patient.</li> <li>• Mobile HEs</li> <li>• Involve the traffic cop</li> <li>• Use patient waiting time to provide intervention</li> <li>• Encourage reimbursement for telephone intervention</li> <li>• Use champions, testimonials from successful clinics, evidence</li> </ul>

**Table 3**

Barriers	Strategies
<ul style="list-style-type: none"><li>• Lack of awareness/knowledge about SBIRT</li><li>• Lack of involvement of wellness community</li><li>• Providers need to be better informed</li><li>• HEs not used to assist with chronic disease/prevention/treatment</li><li>• How to include cultural competence (i.e. HE training/systems approach)</li><li>• Consistency in HE training across the state</li><li>• Start-up money for hiring and training HEs</li><li>• How to fit SBIRT into clinic routine</li></ul>	<ul style="list-style-type: none"><li>• Brokers/consultants need to be included</li><li>• Campaign to educate/advertise</li><li>• Engage all decision-makers</li><li>• Logo for SBIRT/WIPHL could be added to literature and info materials</li><li>• Talk about cost-effectiveness of SBIRT</li><li>• Patient satisfaction surveys</li></ul>

**Table 4**

Barriers	Strategies
<ul style="list-style-type: none"><li>• Ongoing training/supervision of HEs—how to fund</li><li>• Stigma of HE and how to integrate into team</li><li>• Referral services—where and how to fund</li><li>• Battling patients' perception acceptability of alcohol/drug use</li><li>• Ranking of drugs</li><li>• Current fee for service structure (payers/patient)</li><li>• Access</li><li>• Compartmentalization (why only healthcare providers)</li></ul>	<ul style="list-style-type: none"><li>• Link payment and outcome, some paid upfront</li><li>• HEs in jail system (parish nurses)</li><li>• Police, school, church</li><li>• Use community crisis services to find community-based services</li><li>• Integrate more into policies (e.g. school athletic policies)</li><li>• Use BadgerCare \$\$</li><li>• 3-4-minute “elevator speech”</li><li>• Core group of people able to talk with other stakeholders</li><li>• Payers assume risk. Need solid way to show positive outcomes to employers. Win-win-win situation.</li></ul>

**Table 5**

Barriers	Strategies
<ul style="list-style-type: none"><li>• Not sure how cost will grow once door is opened for reimbursement; leads to lack of buy-in by policymakers</li><li>• Payor: this is “Cadillac service,” not basic service</li><li>• Provider: ID those who need treatment, but treatment may not be available</li><li>• Patients: Trust doctor, not the HE</li><li>• Systems level policy</li><li>• Infrastructure</li></ul>	<ul style="list-style-type: none"><li>• ROI argument</li><li>• Medicaid starting (paving the way)</li><li>• Cultural shift; awareness increasing</li><li>• Cost savings transfer to treatment funding</li><li>• Warm handoffs</li><li>• When hiring, recruit from community members</li><li>• Quality measure (WCHQ)</li><li>• Medical records systems</li><li>• Policies, guidelines</li></ul>

**Table 6**

Barriers	Strategies
<ul style="list-style-type: none"><li>• Attitudes of providers/general public, the “culture of Wisconsin drinking”</li><li>• Lack of time</li></ul>	<ul style="list-style-type: none"><li>• Education and training</li><li>• Accumulating outcome results that look at the bottom line</li></ul>

**Table 9**

Barriers	Strategies
<ul style="list-style-type: none"><li>• Coding limits (label each ailment)</li><li>• Quality v. Quantity</li><li>• Service coordination (communication between providers, clear direction when referral needed)</li><li>• Reimbursement for prevention</li><li>• Stigma (downside to coding and electronic health record)</li><li>• Patient expectation of quick fixes (pills)</li><li>• Privacy protections</li></ul>	<ul style="list-style-type: none"><li>• Comprehensive medicine</li><li>• Incentivize quality</li><li>• Measure quality</li><li>• Expand electronic health records</li><li>• Coordinated team</li><li>• Salary or capitation for doctors</li><li>• Focus on prevention</li><li>• Remove pre-existing conditions</li></ul>

**Table 10**

Barriers	Strategies
<ul style="list-style-type: none"><li>• Maintaining HE education after grant runs out</li><li>• Billing for patients who would prefer telephone counseling</li><li>• Stigma</li><li>• Patient time—willingness to meet HE (especially acute care patients)</li><li>• Skepticism of public health and county regarding sustainability</li></ul>	<ul style="list-style-type: none"><li>• Additional grants or gov't funding for continuing education, educating new HEs</li><li>• Make reimbursement available for telephone counseling</li><li>• General healthy behavior screening and intervention (fits with medical home model)</li><li>• Can we offer SBIRT in nonmedical settings? (Raises additional set of barriers, including responsibility, patient confidentiality, payment)</li><li>• HE meet patients outside of business hours</li></ul>

**Table 11**

Barriers	Strategies
<ul style="list-style-type: none"><li>• Language</li><li>• Physicians not usually team players</li><li>• Changing current work flow</li><li>• Lack of ownership (physicians)</li><li>• Cultural behaviors</li><li>• Transportation (patients)</li></ul>	<ul style="list-style-type: none"><li>• Bilingual employees</li><li>• Educating more about program, teamwork skills</li><li>• Buy-in from the top; seeing how others do it</li><li>• Team approach to implementation</li><li>• Diversity training and education</li><li>• Outreach about SBIRT</li><li>• Facilities providing transportation</li><li>• Create a service</li></ul>

**Table 12**

Barriers	Strategies
<ul style="list-style-type: none"><li>• Language pool of available HEs who are bilingual</li><li>• Buy-in from providers</li><li>• Availability of SBIRT services</li><li>• Reluctance to talk about alcohol/substance use; didn't come to clinic to discuss those issues</li><li>• Stigma of having alcohol use in medical records</li></ul>	<ul style="list-style-type: none"><li>• Collaboration with universities and other program staff to identify bilingual folks who can deliver SBIRT services</li><li>• Provide HE space</li><li>• Widening types of sites providing services (clinics/hospitals/EAPs), also expanding days/hours</li><li>• Cultural awareness</li><li>• Determining number of patients needed to support a HE</li><li>• Use general medical code for "diagnosis"</li></ul>

**Table 13**

Barriers	Strategies
<ul style="list-style-type: none"><li>• To using HEs: pool, motivation, support and training for HEs</li><li>• Need infrastructure (tablets, QI)</li><li>• Cost: Payment estimate shown in presentation not a reality for productivity and case mix (variable HE productivity, commercial carriers less likely to reimburse)</li><li>• Health plans don't pay for "non-licensed" professional and if MD not present</li><li>• Phone time not billable</li><li>• Minimal time commitment by patients</li></ul>	<ul style="list-style-type: none"><li>• Expand to diet, exercise, etc. for cost effectiveness</li><li>• Capitated payments</li><li>• Pay for Performance, medical home concept</li><li>• Legislation—educate legislators re: cost-effectiveness</li></ul>

**Table 14**

Barriers	Strategies
<ul style="list-style-type: none"><li>• Communication with patients (language, literacy, cultural)</li><li>• WI alcohol culture</li><li>• Health systems contracts</li><li>• Medical home expansion (very few have this set-up)</li><li>• Where will HE workforce come from?</li></ul>	<ul style="list-style-type: none"><li>• Interpreter service, bilingual HEs, peer-based HEs</li><li>• Multimode approach (in person, by phone)</li><li>• Patient incentives (legislation)</li><li>• Buy-in from top to include expectation that this is standard of care; message role modeling; permission for providers to ask (not just HEs)</li><li>• Payors work with health systems to start medical home demo sites</li><li>• Universal screening of patients in practice</li><li>• Skill-building training for MDs and other providers to learn SBIRT, MI, and use for alcohol and other behaviors in practice</li></ul>