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Nursing schools and community-based organizations experiment with doula-style interventions

A traditional model of pregnancy care shows promise in reaching disadvantaged women

The idea of using community health workers, or nonprofessionals, to provide health-related education and support to disadvantaged populations with chronic disease is becoming more popular. A growing number of healthcare organizations have discovered that people are more receptive to outreach from individuals who share the same cultural or socioeconomic background.

However, although the concept is relatively new with respect to managing chronic disease, it has been used informally for generations to provide care and support to women giving birth. In most instances, insurance does not cover this type of care, but many groups are experimenting with models that make use of doulas, or layper-

sons who have received special training to provide care and support to pregnant women—especially during labor. Medical professionals do not always welcome such support. However, some data suggest that doula-style care can make a considerable dent in the number of cesarean sections that are performed, and many advocates believe that the approach can offer even more dividends to women from high-risk groups.

Inside This Month...

- **Pharmacists have a key role to play in managing patients infected with HIV.** That is the conclusion of a new study showing that clinical pharmacists may well be an underutilized resource in managing patients who are beginning treatment with highly active antiretroviral therapy. And investigators report that their value is particularly noticeable among disadvantaged populations..... p. 29
- **New multidisciplinary care model gives Pfizer another crack at Florida's Medicaid population.** Two years after an earlier DM program was discontinued, Florida is once again turning to Pfizer Health Solutions (PHS) to handle its biggest DM program to date. This time, PHS is bringing more resources to the table and taking on an additional three disease states..... p. 32
- **A new call to action on poor health literacy.** Maintaining that the problem is costing the country dearly in dollars as well as quality of life, The Joint Commission has put out a new policy white paper calling on all key players to take steps to deal with the problem of poor health literacy. Although changes at the top are sorely needed, policy makers maintain that there is much that individual providers can do to alleviate the problem p. 34

Pilot results prompt replication

The doula model is receiving significant support from the Chicago Health Connection, a health education and advocacy group that has worked with partnering organizations to implement doula models at 28 sites in nine states. The organization's work accelerated following a pilot study, showing that a doula-based intervention produced significant benefits in a population of teen mothers.

"[The participants] were almost entirely low-income, and they represented a very diverse group," says Rachel Abramson, RN, MS, executive director of the Chicago Health Connection. "There were three different sites in three parts of the city: One was mostly African American, one was mostly Mexican American, and one served various neighborhoods on the north side."

continued on p. 26

Doula model

continued from p. 25

The study, which was funded by the Robert Wood Johnson Foundation and the Irving Harris Foundation, showed that of the 259 women served at the project's three sites, only 8.1% of the mothers who had a doula present at birth had a cesarean section, compared to 12.9% for Chicago's teen mothers as a whole. Researchers also reported that fewer doula-assisted mothers opted for epidural anesthesia, compared with national statistics, and more of them initiated breast-feeding.

Following the pilot, the Illinois Department of Human Services agreed to continue funding the doula model at the three pilot sites, and the Chicago Health Connection formed the Harris Doula Institute to work toward replicating the model around the country.

Doulas are skilled advocates

Whereas many doula-interventions focus narrowly on providing support to the mother during labor, the Chicago Health Connection's model aims for a more comprehensive interaction. "The idea is to get the [doula involved] as early as possible in the pregnancy, so that she can help the mother get prenatal care, she can develop a trusting relationship with the mother, and so that she really has the time to help the mother attach to the baby," says Abramson.

In addition, she explains that the doula can help the mother think through her plans for delivery, as well as which type of care she wants to give her new baby. This typically includes discussions about breast-feeding, as well as issues related to parenting.

Although doulas are not required to have any type of formal education, Abramson emphasizes that they need to be members of the community they will serve, and they need to be skilled at advocating for themselves and their neighbors.

"They tend to be experienced women who are natural leaders," she says. "They are very committed to helping other women, and for the most part they reflect the same kinds of values, the same language, and the same issues that are faced by their neighbors. So to a certain extent, you could say that they are women

who have survived the same challenges and gotten stronger. And now they are able to use that experience and that strength to support others around them."

However, investigators learned during the pilot involving teen mothers that great care needs to be taken in selecting appropriate doula candidates, because several of the initial hires quit the program and had to be replaced.

"We got a lot better at working with the agencies to help them describe the program clearly both to potential clients and also to doulas they were recruiting," says Abramson, noting that it is important to be clear about the work that is involved, including the fact that doulas need to be on call to attend deliveries at all hours. "It really is as much a mission as it is a job, and we helped our partner agencies . . . to develop questions to help potential doulas think about what the work might be like, what might be hard for them, and what supports they might need in their lives to allow them to do the work."

A number of organizations provide doula training, but the largest such group is Doulas of North America (DONA), based in Jasper, IN (www.dona.org). The training offered through the Chicago Health Connection includes extensive community-based work, enabling doula candidates to pick up baseline knowledge of pregnancy, labor and delivery, the postpartum period for mothers, breast-feeding, and promotion of mother and infant attachment, Abramson says.

Nursing students take on doula role

Another doula model, Birth Companions, has received national recognition for the support it provides to underserved pregnant women in the Baltimore area.

The program, established in 1999 through the Johns Hopkins University School of Nursing in Baltimore, pairs nursing students who have received doula training from a DONA-certified instructor with expectant mothers as part of its community nursing program. Data suggest that mothers involved with the program are less likely to have preterm or low-birth-weight babies and are less likely to have a cesarean

continued on p. 28

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Web-based support: An avenue for intervention in low-income pregnant women

For reasons that are not entirely clear, African American babies are twice as likely as Caucasian babies to be born with a low birth weight, making them much more vulnerable to medical complications and developmental disabilities. Some researchers theorize that a strong contributing factor to this discrepancy may be higher levels of stress in mothers.

"There is a lot of new literature on the relationship between stress and preterm labor," says **JoAnne Herman, PhD, RN, CSME**, an associate professor at the University of South Carolina, who has researched the issue extensively. "Some of the stress hormones that are produced can trigger preterm labor."

Given that there is also ample evidence that social support can buffer the impact of stress, Herman decided to investigate whether an interactive Web site could potentially have an effect on the rate of preterm births in a low-income, African American population. To answer this question, Herman first conducted a feasibility study to assess whether her target population would take advantage of a Healthy Pregnancy Web site, designed with their particular needs in mind and offered via phone lines and Web-TV.¹

At the time (December 2001–August 2003), the prevailing view was that African American women with low incomes would not use such a resource, says Herman, but she discovered that this view was not necessarily correct. In fact, participants accessed the Web site 11 times, on average, during the study period.

"Just the fact that I can document that they used it and had a lot of discussion through the discussion-board feature helped [people] get over the idea that this particular population wouldn't use such a resource," says Herman.

Herman was also able to assess which features of the Web site were most popular and, therefore, potentially the most useful in getting important information and support across to the target population. She noticed, for example, that users particularly liked interactive features in which they could input information about themselves and receive feedback. Features that fit this description included a tool with which users could calculate the gestational age of their baby, and a nutritional assessment tool in which they could enter what they had eaten on a given day and receive dietary recommendations in return.

Users also liked being able to post ultrasound images of their babies to share with other users—a feature they actually suggested to site administrators. "They liked having something about themselves on the Web site; that was really powerful," says Herman.

The most popular feature was the discussion board, on which users could interact with each other and share solutions to problems. Consequently, for the next phase of her research, Herman hopes to leverage the popularity of this feature to communicate important educational topics to users, perhaps through the use of moderated discussions.

Herman is still waiting for grant funding so that she can move on to the next phase of her research, which will not only look at specific birth outcomes in women who have had access to Web-based support, but also pre- and postmeasures of stress.

Reference

¹Herman J, Mock K, Blackwell D, et al. "Use of a Pregnancy Support Web Site by Low-Income African American Women." *JOGNN* 2005; 34:713-720.

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Doula model

continued from p. 26

delivery when compared to regional and national benchmarks.

“Our focus is really with women who are underserved or who will be alone during the birth process, but we really don’t limit our services,” says **Elizabeth Jordan, DNSc, RNC**, assistant professor at the Johns Hopkins University School of Nursing and a faculty mentor to students participating in the Birth Companions program. “If someone calls and has a need for the program, we certainly provide the service to them.”

The program maintains an English- and Spanish-speaking phone line that women can call to request the service. In addition, program staff maintain relationships with more than 40 community sites and practice groups that typically refer patients in need of pregnancy support to the program.

The stage at which student nurses get involved with an expectant mother depends on how early in her pregnancy a woman contacts the program. However, Jordan says that 70% of the time, student nurses are able to do at least one prenatal visit with the woman.

“They may meet at the doctor’s office or a testing center, but the student nurse sits down with the pregnant woman and really develops what the mom would like for her birth plan,” says Jordan. “And if at that time there is any need to help the patient navigate the health-care system or identify community resources, that will be set into action as well.”

Staying in touch is a challenge

As with the Chicago Health Connection’s program, Birth Companions will individualize the care and support according to the woman’s needs and where she is in her pregnancy. For example, if the woman is diabetic, Birth Companions provides counseling and education that is pertinent.

“I and another faculty member are always there as support for the students, so if they are not sure about something, they can always call us,” adds Jordan. “That is our role—to help the student understand what might be available for the client, and what the situation is because every situation is a little bit different.”

Many of the women who call or are referred into the program are at very high risk for adverse birth outcomes, because of either psychosocial or medical problems. Jordan recalls one case that involved a woman with a limited education who was mentally retarded, for example. Other cases involve women struggling with addictions or abusive situations in the home.

“We may not provide the actual resources [that the

women need], but we help them know whom to call, when to call, and how to call, so we really help them navigate,” says Jordan, noting that sometimes the Birth Companion will actually accompany the women to the appropriate agencies to fill out paperwork needed to obtain benefits. “We may even pick up the phone and help them work through an initial phone call or make that initial appointment.”

Within two weeks of delivery, the Birth Companion tries to visit the mother in her home to make sure that she and her child have gotten off to a good start. However, this is not always easily accomplished, as many of the women stay with friends or relatives immediately following the birth. However, the doula will make every attempt to connect with the woman in some fashion and assess how she is doing.

Jordan adds that throughout the entire process, just staying in contact with the women is a real challenge for the doulas. “These women move so much and change phone numbers so much that the nursing students often cannot find their clients,” she says. “When that happens, we tell the student to go back to where they got the referrals from and try to track them down.”

Patients connect with dedicated students

Because the Birth Companions program fills a variety of needs for its clients, it is difficult to determine which elements are responsible for the improvement in birth outcomes. Jordan says that both the education and support functions probably play a role.

“It could be that we have done a better job of explaining to the women what preterm labor is so that they don’t show up in labor at 8 cm, but rather when they are having a few contractions so that [medical treatment] can stop the labor,” she says. “We know when we provide that kind of education we are hopeful that these babies weigh more and are healthier as a result.”

Birth Companions has been so well-received that other communities are modeling their own efforts after the program. Jordan believes the success of the effort stems largely from the fact that the nursing students elect to become Birth Companions because they have a strong interest in women’s health, and many of them go on to become nurse practitioners or nurse-midwives.

“These are very dedicated students who want to learn and understand the needs of women in the community, and they are very motivated to get out there and help women,” she says. “It’s a passion for them and they want to do it, and I think that’s why patients connect.”

Doula advocates target high cesarean rate

Although the student nurses involved with the Birth Companions program have a high degree of

medical expertise as well as doula training, most of the studies focusing on doula care have looked at the effect of utilizing modestly trained members of the community, as in the Chicago Health Connection's model. And data show that the intervention not only results in fewer medical interventions during delivery, but it also produces a more positive birth experience for mothers, according to **Carol Sakala, PhD, MSPH**, director of programs at Childbirth Connection, a New York City-based, non-profit organization focused on improving maternity care, and coauthor of the *Cochrane Review* on continuous labor support.

Of particular concern to Sakala and other advocates of the doula model is the high rate of cesarean deliveries in the United States. Statistics suggest that cesarean deliveries account for as much as 30% of all deliveries—a figure Sakala attributes to system pressures rather than medical need.

"The bar is shifting to where there is more and more causal use of this procedure," she says. "So there is something going on that has nothing to do with the need, interest, or capacity of women and their preferences. It has much more to do with the healthcare system."

Sakala points to reimbursement policies, time constraints, and fear of litigation as contributing to an unnecessarily high cesarean rate. "The pressure is to practice in an efficient manner, and the most efficient

of all is a planned cesarean," she says. "You know when it is going to happen, and you can provide scheduling for the nursing staff and operating room, so that is a very efficient way to do it."

Further, although a routine cesarean delivery costs almost twice as much as a routine vaginal delivery, there is little incentive for hospitals to curb the rate of cesareans because the procedure provides an important revenue stream. However, Sakala points out that a doula-style intervention should have strong appeal to policymakers interested in lowering overall medical costs. "The ROI is a no-brainer," she says. "It is really very simple, because for every four women who are getting doula support, you save a cesarean."

In an effort to develop a much larger database on outcomes related to different doula practices, the Chicago Health Connection is developing a Web-based collection system so that partnering organizations can enter client-based data and compare the results of various process factors with those employed by other models. The idea is to facilitate a network of community-based doula programs around the country so that best practices can be identified and disseminated, explains Abramson.

"It is in all of our best interests to share the data, use it to advocate for the model, and attract funding for further expansion around the country," she says. ❖

Study suggests pharmacists may be underutilized, especially in low-income populations

Specialty pharmacists boost the care and compliance of HIV-infected patients

A number of studies suggest that pharmacists bring unique contributions to the table in working directly with patients on difficult or complicated drug regimens. In fact, models of care that use pharmacists for lipid management, diabetes care, and anticoagulation therapy have been well studied. However, until recently, there were few data showing the effect that clinical pharmacists can have on caring for patients infected with HIV who are beginning treatment with highly active antiretroviral therapy (HAART).

In fact, few healthcare organizations routinely use clinical pharmacists in the care of HIV-infected patients. However, Kaiser Permanente has implemented this type of care at several of its clinics in California, and investigators from Kaiser's Division of Research in Oakland have just unveiled data suggesting that

the approach not only promotes positive clinical outcomes in HIV patients, but also is especially beneficial in disadvantaged populations.¹ Further, in clinic settings where pharmacists work directly with HIV patients, researchers find that patients require fewer office visits.

Value is evident in low-income subgroup

The lead investigator on the research, **Michael Horberg, MD, MAS, FACP, AAHIVS**, wanted to quantify the value or lack of value that pharmacists offer in working with HIV-infected patients, and the Kaiser system presented ideal conditions for an observational study of this sort, because some of the clinics had HIV-clinical pharmacists on staff and some did not.

Horberg strongly suspected that the pharmacists did offer value, but to test that hypothesis he and colleagues analyzed data from more than 1,500 HIV-infected patients who began on HAART between 1977 and 2002. Then, looking at a two-year period, they compared clinical and utilization measures from the

continued on p. 30

HIV

continued from p. 29

patients who received care at clinics that had HIV-clinical pharmacists to similar data from patients cared for at clinics that did not have the specialty pharmacists.

Researchers found that patients who had access to a clinical pharmacist on their care team had two times greater odds of achieving complete viral control, and had a 19% decrease in office visits when compared with the patients who did not receive care from a pharmacist.

The benefits associated with the pharmacist were particularly dramatic among HIV-infected patients residing in low-income areas. Among this subgroup of patients, those who had access to an HIV-clinical pharmacist were three times more likely to achieve total viral control than were patients who did not have access to a pharmacist.

The effect on utilization in this subgroup was striking as well: Patients with access to a pharmacist had 66% fewer days of hospitalization and 43% fewer office visits than patients who did not have access to a pharmacist.¹

"These are patients who probably can't navigate the system as well and end up in the ER and in the doctor's office more often because of poverty-related life stressors," says Horberg. "The clinical pharmacist is there to help mitigate a lot [of these issues] and provide better access to the system."

Compliance is challenging

In fact, the responsibilities of the HIV clinical pharmacist vary somewhat from clinic to clinic in the Kaiser system, but Horberg says organizational policy requires every patient starting on HAART to consult with the pharmacist in every clinic where one is on staff. During these sessions, the pharmacist educates patients about why they need to take their medicines and how to take them correctly. Further, he or she will discuss potential side effects and how to manage them if they occur.

Jennifer Yu, PharmD, the HIV-clinical pharmacist in Kaiser's Santa Clara, CA, clinic, says that she also spends a lot of time working with patients to establish a medication schedule that will work for them, because compliance is especially challenging in this group. "We are asking a lot from these patients," she says. "We are asking them to comply with their medicine at least 95% of the time, because that is what the literature tells us is what they need to ensure viral suppression."

Once patients understand what the consequences are of noncompliance, they are often more willing to change

their work schedule or make other adjustments that will enable them to take their medications as directed, adds Yu. However, she also counsels patients on strategies that can help them to be more compliant.

"If the medicine has to be taken with food once a day, I will find out what is the most regular meal for a patient so they can take the medicine every day at that time," she says. "Alternatively, in cases where patients don't like to bring their medications to work, the evening is a better time to take their medications. So, I sit down with the patient and come up with a plan, but it is very individualized."

Pharmacists advise patients and clinicians

In addition to having in-person office visits with all of the patients starting on HAART, Yu also acts as a case manager for a large number of the patients she sees. This involves making follow-up calls at two, four, and six weeks after patients have started on HAART. During these communications, Yu will address any problems the patients are experiencing, and with the help of pharmacy claims information to which she has access, Yu makes sure that patients continue to be compliant.

"I also check to see if they have started taking any new prescription or over-the-counter medications that could interact with the HIV medications," she explains. "I make sure they have undergone appropriate blood tests based on the medications they are taking, and that they have appointments scheduled with their doctor on a regular basis."

Additionally, given the close working relationship she establishes with patients, Yu is often the person they call when they have questions or experience difficulties managing their disease. In many cases, Yu can resolve the problem herself by phone, but when appropriate she communicates with the physician to find out what further action he or she recommends. In cases involving drug interactions or troubling side effects, Yu typically works with the physician to resolve the issue.

It is not unusual for Yu to encounter patients who have difficulty affording the drugs prescribed to them. In these cases, she usually refers patients to a benefits coordinator on staff at the clinic who can assist patients in linking up with pharmacy assistance programs.

In addition to consulting with patients, the HIV-clinical pharmacists also are available to physicians who may have questions or concerns about various therapeutic approaches. Horberg observes that the added input and assistance provided by the pharmacists are largely appreciated by physicians, but he cautions that this may be partly a result of the unique characteristics of the

Kaiser system. "We utilize clinical pharmacists a lot for complex chronic conditions," he says. "There is a culture in place that values [the approach]."

Yu agrees, noting that physicians appreciate having another professional on hand to make sure that appropriate care is provided and up to date. Further, she observes that physicians are mindful of the personalized care and attention that pharmacists are able to provide to their patients.

Further study is needed

Although investigators found that the HIV-clinical pharmacists were associated with improved adherence and reduced office visits, they did not find any correlating improvement in CD4 T-cell counts, which are a measure of viral control. "With the use of HAART, both groups had significant increases in the CD4 T-cell counts, but the rise in either group was not significantly different from the other," adds Horberg, noting that this is

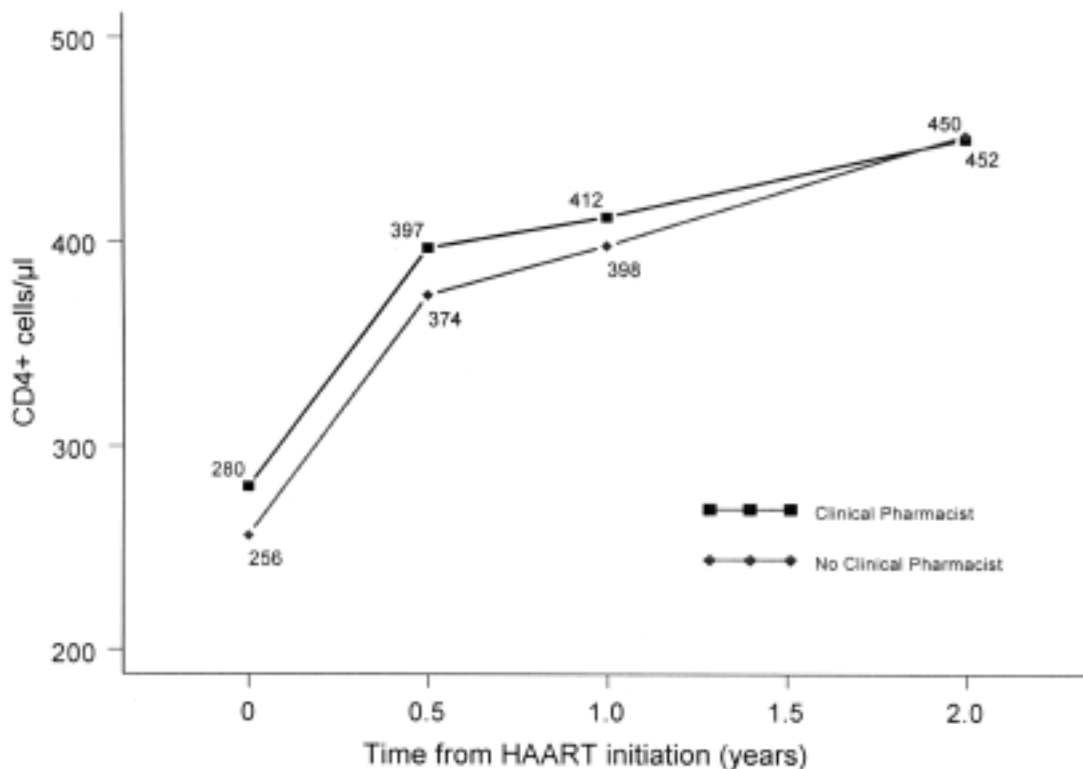
a result he cannot explain, given that improvements in adherence should be associated with improved CD4 T-cell counts (see Figure 1 below).

Additionally, as Horberg only looked at the role of the HIV-clinical pharmacist, it is unclear whether another type of personnel might be able to provide similar benefits in terms of boosting medication compliance. Horberg hopes to look at the contributions of other healthcare professionals in future studies, but he points out that the current study already suggests that clinical pharmacists may well be an underutilized resource—especially in the public health sector. ❖

Reference

¹ Horberg M, Hurley L, Silverberg M, et al. "Effect of Clinical Pharmacists on Utilization and Clinical Response to Antiretroviral Therapy." *Journal of Acquired Immune Deficiency Syndromes*. Copyright 2007 Lippincott Williams & Wilkins, Inc.

Figure 1: Two slope unadjusted mean CD-4 T-cell counts over time for the two groups



Mean CD4 T-cell counts (cells/uL) at time points displayed above.

Slopes and random intercepts estimated using linear mixed models accounting for incremental changes in CD4 T-cell counts over time. For difference in slopes, $p=0.94$ for months zero to six, and $p=0.02$ for months six to 24.

Source: Horberg M, Hurley L, Silverberg M, et al. "Effect of Clinical Pharmacists on Utilization and Clinical Response to Antiretroviral Therapy." *Journal of Acquired Immune Deficiency Syndromes*. Copyright 2007, Lippincott Williams & Wilkins, Inc.

Pfizer Health Solutions gets tapped once again to handle Florida's largest DM contract

Care managers have more resources at their disposal in new Medicaid effort in Florida

Two years after deciding to discontinue what had been the state's largest Medicaid DM program to date, Florida's Agency for Health Care Administration (AHCA) has elected to try again. The agency is working with the same vendor that implemented the earlier program on an expanded DM effort that is expected to provide education and coaching support to more than 90,000 Medicaid beneficiaries with chronic disease.

Beginning in January, Pfizer Health Solutions (PHS), the New York City-based care management subsidiary of Pfizer, Inc., began implementing Healthier Florida. The program has many similarities to its predecessor, Florida: A Healthy State, but administrators point out that, in addition to including some new disease states, program components have been enhanced to put more services at the disposal of nurse care managers and the patients they serve.

Also, as with the earlier effort, Broomfield, CO-based McKesson Health Solutions (MHS) is playing a prominent role in the approach—this time assembling all of the multidisciplinary teams that will work within various state regions to meet the care needs of enrolled beneficiaries.

Pfizer proposal offers security

Even after Florida: A Healthy State formally ended in 2005, both Pfizer and McKesson continued to work in the state, providing DM services to Medicaid recipients. In the meantime, AHCA prepared an invitation to negotiate, which attracted bids from several DM vendors interested in launching the new program. Evaluators considered many factors when examining the various proposals, but Pfizer's earlier work in the state had little to do with winning the new contract, says **Sybil Richard**, COO of Florida's Medicaid program. AHCA asked for bids on four specific DM programs—CHF, diabetes, hypertension, and asthma—with the option to include another three programs focused on sickle cell anemia, renal disease, and chronic obstructive pulmonary disease, says Richard.

"One of the things that was attractive in Pfizer's program was that they didn't just bid on the initial four DM programs; they bid on [all seven programs], and although our comprehensive DM program might have been based on the four programs that were already operational in the state, their proposal gave us some security that we could move forward with new

programs," Richard says. She adds the state never intended to discontinue offering DM services, but rather it wanted to devise a different funding stream for these services, which it has done with the new contract. Additionally, AHCA awarded the new program to Pfizer based on a competitive process that was not in place when it awarded the earlier contract.

More resources are at hand

Under Healthier Florida, nurse care managers will still be the primary points of contact for beneficiaries enrolled in the program, but Pfizer is applying a much more multidisciplinary approach this time around, according to **Donna Litchi, RN**, senior director and team leader for state and international initiatives at PHS.

"Where we had care managers and diabetes specialists [before], we now have care managers, behavioral health specialists, pharmacists, social workers, and community health workers," she says, noting that Pfizer discovered that the care managers needed to have a deeper breadth of professional help.

"We realized that these patients have multiple needs, and there is never really one specific thing that is driving the problems," says Litchi. "When you have someone who has multiple comorbid conditions and a lot of social problems, you can't really focus in on a disease when you have so many social issues occurring."

There is, in fact, a large mental health component involved to caring for this population, says **Diane Creal, RN, CNS**, the director of program launches at MHS. "We are fortunate to have individuals who focus specifically on some of those sickest patients who have mental health issues, so it is a very comprehensive, holistic model," she says.

Further, whereas nurse care managers involved with the earlier Pfizer program devoted some of their time to community outreach, the new effort incorporates community health workers into the care teams so they can focus all of their efforts on community-based work.

"These are people who are familiar with their own community, and many times they are familiar with the particular diseases [affecting patients]," says Litchi, noting that this type of cultural familiarity and understanding elicits trust from recipients.

The community health workers fulfill some patient education functions, including setting up group classes for recipients with similar diseases. In addition, they are available to the nurse care manager for any number of tasks. "In the past, if the nurse had a patient whom she suspected could not read . . . and there was a medication compliance issue, she would have to do the best she could with that," says Creal. "Now, however, she can deploy her local community health

worker to the patient's home to [evaluate the issue]." The extra support, not only from the community health workers, but also from the entire team, gives the nurse more control over the outcome of the patient, she says.

Contact is a challenge

The state and PHS have developed multiple ways for patients to be referred into the program. However, the state identifies most potential candidates initially through claims analysis. It then passes on this information to PHS for further analysis and stratification. The critical factors considered at this stage are specific diagnoses, utilization history, and time of diagnosis, explains Lichthi. "Based on this stratification, the nurses will know how to outreach to the patient, and they will also know who their PCPs are," she says.

In this population, it can be very difficult to make contact with patients. Consequently, PHS is employing several communications strategies, including phone calls, mail, physician referrals, and in-person contact. "You have to use many different vehicles," Lichthi says. "Sometimes we use the Medicaid offices as well."

Once a care manager has made contact with a recipient, and the recipient has agreed to participate in the program, it may take several phone calls to get through the initial assessment. "The nurse has to make some determinations about how to start," says Lichthi. "Some of the things they need to capture include verifying the last time the recipient was in the hospital, who their PCP is, what medications they are taking and how frequently, what symptoms they have, and what they know about their illness."

When recipients have a PCP, the care managers will also make contact with the provider to get his or her input on the recipient. However, in cases in which there is no PCP, one of the first goals of the care manager will be to establish a medical home for that recipient.

"It is important to have someone they can go to a regular basis," says Lichthi. "Obviously, we want to avoid ER visits, so really getting someone started on a program with a PCP who can follow them, as well as any specialty physicians that they need, [is critical]."

As the relationship between the care manager and patient develops, the nurse will begin to understand what motivates the patient, and he or she can then target those issues where there is the most potential for improvement. For example, in the case of a patient who has diabetes, weighs 250 lbs, is a smoker, and cannot afford the cab fee to get to a physician's office visit, Lichthi explains that the nurse will ask probing questions to home in on areas in which the recipient is ready to make some changes.

"The care manager really tries to be a friendly coach, a mentor, and a cheerleader for the things that are important to that person," she says. "So while the recipient might not be ready to talk about smoking cessation, she might be willing to get out and walk around the block a few times each week. That might be the beginning of an exercise program, so the nurse will establish some goals around that." During the next call, the nurse will determine whether the recipient made progress with those initial goals, and then he or she will proceed from there, adds Lichthi.

Everything is local

Creal, who has been responsible for putting personnel in place to implement McKesson's part of the model, emphasizes that it was important to build the multidisciplinary care teams from the regions they will be serving. "If you want to do this right, you've got to do it locally," she says. "What is happening in the northern part of the state may be very different than what is happening or working in the southern part of the state. And now I have teams specifically focusing on those areas so that we can get that feedback."

Ramping up for the program has been a huge endeavor, requiring months of touring the state, interviewing, and hiring. However, Creal points out

continued on p. 34

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that there was a wide pool of applicants interested in participating.

"This is unique, and as I talked to social workers, pharmacists, and dietitians, they found it to be a very different career path," she says, adding that the model had particular appeal to care managers. "This is truly primary care nursing where you have those resources available, and you can pull them in, so it is good for the patient, the nurse, and the team."

New white paper offers an array of potential solutions

The Joint Commission calls for comprehensive action on poor health literacy

Low health literacy is a much bigger problem than most healthcare professionals realize, affecting nearly half of all Americans, according to The Joint Commission.

In fact, calling the problem a silent epidemic, the Oakwood, IL-based accrediting organization has unveiled a public policy white paper outlining a long list of recommendations designed to guide individual providers and healthcare organizations toward formulating solutions.

Although poor health-literacy affects all facets of healthcare, it is particularly damaging to chronically ill patients who may have difficulty learning and understanding important self-management skills.

The problem is compounded by the fact that people with low literacy often do their best to hide reading deficiencies, because they lack confidence or feel ashamed.

There is no doubt that poor health literacy costs the country dearly in terms of quality of life as well as dollars spent on complications or mistakes that occur as a result of communication gaps.

Consequently, policy makers maintain that it is in everyone's best interest to participate in a comprehensive solution.

How well the model will work in terms of producing good clinical and financial results remains to be seen, but the idea of linking the many facets of care had strong appeal to the state.

"It does not help the patient to have systems of care where the providers aren't talking to each other," says Richard.

"We are all about integrative care," she adds. "That is what our Medicaid reform model is [focused on]: bringing all of the pieces together in the treatment of whole health—both physical and behavioral healthcare from one system of care." ♦

Problem is widespread

In unveiling its white paper *What Did the Doctor Say?: Improving Health Literacy to Protect Patient Safety*, The Joint Commission emphasizes that in its own active database, which documents more than 3,000 preventable deaths and serious healthcare injuries and their underlying causes, analysts have identified communications failures as a contributing factor in almost 70% of the cases.

"While not all of these relate to health literacy or language and cultural barriers, many likely do," says Dennis O'Leary, MD, president of The Joint Commission. "We need to reflect on the fact that if a patient does not understand his or her illness, what medicines need to be taken, how to take them, and why these medicines are important, we have lost the treatment battle at the beginning, and we may have unwittingly placed the patient in harm's way."

—Dennis O'Leary, MD

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Communication problems are not only affected by poor health literacy, but also by language barriers and cultural differences, adds O'Leary. And individual providers often don't realize that there is a problem. "When I went to medical school, no one warned me that up to half of my patients might not be able to understand me," says O'Leary. "And today, many physicians believe they have been clearly understood by the patient when clearly they have not."

The white paper (available at www.jointcommission.org) outlines 35 steps that providers and healthcare organizations can take toward remedying the problem. These include

- training and education for clinicians and allied

personnel on the scope of the problem, as well as on patient-centered communication strategies

- development of patient-friendly navigational aides at healthcare facilities
- healthcare organization assessment of literacy levels and the language needs of the communities they serve
- integration of patient communication priorities into pay-for-performance programs
- provision of medical liability discounts for physicians who apply patient-centered communication strategies
- expanded adaptation and use of adult learning centers to meet patient health literacy needs
- redesign of informed consent forms and the informed consent process
- enhanced training and use of interpreters for patients

Providers should be aware of other clues

Experts agree that taking on the issue of low health literacy is a major undertaking that requires the participation of all key players. However, there is a lot that individual providers can do to address the issue in their own practices. "The bottom line is awareness that the patient who smiles at you and nods their head doesn't necessarily understand what you said," says J. James Rohack, MD, chair of the American Medical Association's Board of Trustees, and a practicing cardiologist in Temple, TX.

Rohack advises providers to use the "teach-back" method to confirm that patients fully understand what you have attempted to communicate. This involves simply asking patients to explain back to you the instructions or education that you have just delivered to them.

It takes some time, but Rohack emphasizes that it is a simple way to confirm that patients comprehend important medical information.

Rohack also advises providers to be aware of other clues that their patients may have low literacy skills. For example, he uses the medical history form to pick up on communications deficits. "If patients don't fill out the form, that is a clue; or if they are not able to write down what medicines they are on, that's a clue," says Rohack.

When there is a communication deficit, Rohack emphasizes that providers and front office staff need to take special care to make sure patients do not feel that they're responsible for the problem.

"The patient has to feel that we in the doctor community . . . are not blaming or shaming him [or her], and that we understand that there is a communication need that we need to meet in a different way other than the written word," says Rohack. "If we can't communicate, we can't provide good patient care, we can't provide good quality care, and we certainly can't provide safe patient care."

Even with patients who are highly literate, sometimes physicians give them more information than they can absorb in one setting, notes O'Leary.

A better strategy, he says, is to prioritize the information into two or three main points during each encounter.

In fact, such planning can be essential when trying to impart key self-management skills to the chronically ill. "Patients who are good at self-management are much less likely to end up being hospitalized, so it is a way of reducing healthcare system exposure and keeping people healthy," he adds.

Reimbursement policies need attention

Making sure that patients clearly understand instructions requires more time, but

O'Leary says that it is "time that is incredibly well-spent."

Consequently, he points out that payers need to devise ways to reimburse providers for this time.

"It really is a challenge where time constraints are increasingly a problem in physician practices, and payment systems really don't

properly recognize the needed effort on the part of physicians," he says.

In addition, O'Leary maintains that medical liability insurers have a strong stake in the issue as well.

"They know as well as we do that communication issues are a huge patient safety problem," says O'Leary. "That is a big exposure for practitioners and provider organizations, so anything [medical liability insurers] can do to encourage more effective communications between doctor and patient is a business proposition for them."

For example, O'Leary notes that medical liability insurers could provide discounts to physicians who can demonstrate that they meet expectations in this area.

In its accreditation work, The Joint Commission plans to refine its own standards with regards to National Patient Safety Goals so that surveyors focus more attention on communications strategies that organizations employ to circumvent poor patient-literacy skills and other communication barriers. ❖

"The bottom line is awareness that the patient who smiles at you and nods their head doesn't necessarily understand what you said."

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DM briefs

New resource for tobacco-cessation training

Healthcare professionals interested in gaining more insight on tobacco cessation have a new online resource available from the American Society of Addiction Medicine and Clinical Tools, Inc. The organizations have just launched a new Internet-based training program designed to prepare physicians and other clinicians to provide interventions for prevention, as well as cessation. The Tobacco Treatment Training Program was developed with funding from the National Cancer Institute and the National Heart, Lung, and Blood Institute. Those who complete the program can earn between eight and 10.5 hours of continuing medical education credit. More information about the program is available at www.tobaccotreatmenttraining.com.

Alzheimer's patients to receive implantable microchips equipped with medical info

Delray Beach, FL-based VeriChip Corporation has announced that is partnering with Alzheimer's Community Care, Inc., to study the effectiveness of using the VeriMed™ Patient Identification System to keep track of the medical information of Alzheimer's patients and their caregivers.

During the two-year study, 200 patients with Alzheimer's or other forms of dementia will receive the VeriMed implantable microchip so that emergency department staff can easily access their identification and medical information.

The system allows physicians to obtain this information by scanning a patient's arm where the microchip has been implanted.

By obtaining the individual's identification number from the microchip, physicians can then access the VeriMed database to obtain caregiver and provider information, diagnoses, current medications, and other medical data.

The system uses the first human-implantable passive radio-frequency identification microchip, which was cleared by the FDA for medical use in October 2004.

For more information, visit VeriChip Corporation's Web site at www.verichipcorp.com. ❖

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