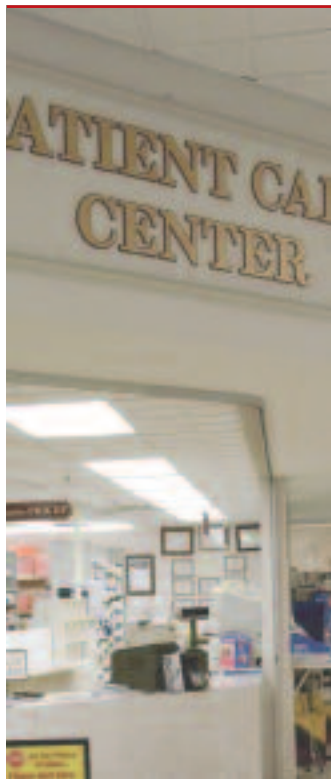


Pharmacy Times[®]

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Practical Information for Today's Pharmacist

BEYOND ASHEVILLE



*A Successful Replication
of a Health Management Model
that Benefits All Stakeholders*



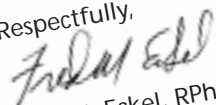
Across the country, health care stakeholders—patients, physicians, pharmacists, employers, and payers—are coming to appreciate the idea that drug therapy outcomes can be optimized with active pharmacist involvement. And with the Asheville model, innovative payers are coming to appreciate that health care can be viewed as an investment in well-being rather than an expense for sickness.

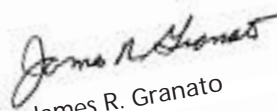
An important aspect of this new approach to disease state management is the notion of collaboration and communication across the health care team, with the patient at the center. When this model works effectively, everybody benefits—patients are healthier, physicians are afforded more time to do what they do best, pharmacists are developing thriving patient care services in their community pharmacies, and payers are experiencing reduced costs.

We at *Pharmacy Times* are pleased to have the support of GlaxoSmithKline in presenting *Beyond Asheville*. This supplement sets forth the evidence showing that pharmacists are making a positive impact on drug therapy outcomes. It is offered as both a demonstration of what pharmacists are doing and a guide on what you can do in your practice.

When medications are used appropriately everyone benefits. This publication documents that the disease management model pioneered in Asheville can be easily duplicated when patients, providers, and payers work together. The result is improved well-being at a reduced cost. Pharmacy's challenge is to spread this concept to benefit more patients. As this supplement demonstrates, the pharmaceutical industry can be our partners in this effort to the benefit of all.

Respectfully,


Fred M. Eckel, RPh, MS
Editor-in-Chief
Pharmacy Times


James R. Granato
Publisher
Pharmacy Times

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Practical Information for Today's Pharmacist

A Successful Replication of a Health Management Model that Benefits All Stakeholders

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Additional copies of *Pharmacy Times—Beyond Asheville* are available on request. Contact Lisa Russo at lrusso@ascendmedia.com.

A Successful Replication of a Health Management Model that Benefits All Stakeholders



Photo courtesy of Brian Strickland/ZUMA

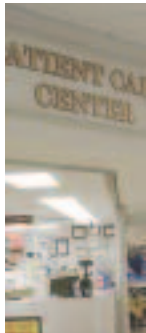


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Beyond the Asheville Project: Are We in the Middle of a Tipping Point?

Daniel G. Garrett, RPh, MS, FASHP

Photo courtesy of Bryan Rimmer/ZUMA

The Asheville Project began in 1996 as the City of Asheville, a self-insured employer, sought to provide education and personal oversight for employees with chronic health problems, such as diabetes, asthma, hypertension, and high cholesterol. Under the Asheville Project, employees with these conditions were provided with intensive education through the Mission-St. Joseph's Diabetes and Health Education Center. Then patients were teamed with community pharmacists who made sure they were using their medications correctly. The project resulted in a system in which pharmacists developed thriving patient care services in their community pharmacies, with employees, retirees, and dependents with diabetes experiencing improved A1C levels, lower total health care costs, fewer sick days, and increased satisfaction with pharmacists' services.

Recently on ABC's "Nightline," the host, Ted Koppel, posed an intriguing question to Malcolm Gladwell, the social scientist who wrote the book *The Tipping Point*, which is about how changes in behavior or perception can reach a critical mass and a whole new reality. Koppel asked, "Can you know you are in the middle of a tipping point, or is it only something you can see in retrospect?"

Gladwell responded, "the most important thing in trying to analyze whether something is at the verge of a tipping point is whether it—an event—causes people to reframe an issue. A [bad] example is the Atkins diet, which reframes dieting from thinking about it in terms of avoiding calories and fat to thinking about it as avoiding carbohydrates."

A smart example of an event that has reframed the way progressive payers evaluate their investment in health care is the Asheville Project. In the Asheville model, the payer realigns the incentives for patients and providers to maintain their health, rather



Daniel G. Garrett

than wait until the patient gets sick and needs acute medical services. By reframing the way payers think about health care costs from individual silos for hospital services, physician services, medications, and pharmacist counseling/coaching services, the Asheville Project stimulated other innovative payers to begin to look at health care as an investment in well-being rather than an expense for sickness.

The pages that follow in this supplement explore the experiences of payers, patients, and pharmacists who are pioneers in the adaptation of the Asheville Project into the Lakeshore Project in Wisconsin, the Dublin Project in Georgia, the Columbus Project in Ohio, the Blue Ridge Paper Project in multiple states, the REACH Project in Kentucky, the VF Project in North Carolina, and the West Virginia Project.

The American Pharmacists Association (APhA) Foundation has collected and analyzed data from 5 of these sites. An article in the March/April issue of the *Journal of the American Pharmacists Association* states, from the employers' perspective, the key findings of this program included the following:

- Diabetes control improved remarkably, compared with both baseline and national standards such as HEDIS [Health Plan Employer Data and Information Set]. PSMP [Patient Self-Management Program] Diabetes patients had mean A1C levels of 7.1%, near the goal of 7.0% set by the American Diabetes Association.
- Other key indicators of diabetes care—such as influenza vaccinations, blood pressure, lipid profiles, and the percentage of patients receiving foot and eye examinations—also improved substantially.
- More than 95% of the patients reported that they were either very satisfied or satisfied with care provided by the program pharmacists.
- Employers were able to evaluate the economic impact of the program across the spectrum of total health care costs, as compared with their



Photo courtesy of Craig Cunningham/ZUMA

previous silo-based evaluations that considered medical and pharmacy claims separately. This is important because baseline health care cost distributions shifted from 69% to 56% for inpatient and outpatient medical services, with a corresponding shift from 31% to 44% for medication and medication management services.

- Substantial reductions in total health care costs were demonstrated based on employers' projections and national data for demographically similar patients.
- Additional proof of the value of the program and the utility of the outcomes measured is evidenced by the decision from all of the participating employer sites to continue the program beyond the pilot and to expand it to other sites in their organizations.

These results demonstrate that the Asheville Project can be reproduced in a wide variety of settings with diverse workforces. The clinical, economic, and humanistic improvements are similar wherever the program is implemented, and the results are statistically significant.

As a result of their investment in true health care, employers are experiencing for the first time a reversal in the steep inflationary cost of medical care. Also, better care and empowered self-management of a chronic disease translates into happier employees and a workforce that positively approaches each day's work. These programs provide government payers an important lesson in health care economics—one of relevance to Medicare Part D and its medication therapy management services—investment in medications and medication therapy services decreases overall medical costs.

These results demonstrate that the Asheville Project can be reproduced in a wide variety of settings with diverse workforces.

So, are we in the middle of a “tipping point”? In 1997, an interesting experiment began in Asheville to reframe the way we look at health care, and in 1998, *Pharmacy Times* published a supplement about the initial results from a program that is now known internationally as the “Asheville Project.” A few innovators who learned about the Asheville Project have used the model to reframe the way they look at health care in their communities. Now in 2005, we have the data to prove that the model can be replicated. It is rare that a day goes by that the phone does not ring at the APhA Foundation from someone else who wants to know more about the Asheville Project and the APhA Foundation PSMP. As you read the following stories, think about how you can reframe your perceptions and decide what you can do to transform the health care system in your community. And join us as we journey through the tipping point. ^P

What It Takes to Replicate the Asheville Project

Photo courtesy of Bryan Rimmer/ZUMA

By Barry A. Bunting, PharmD; Daniel G. Garrett, RPh, MS, FASHP; J. Paul Martin, MD; Brian Moore, MHSA; Jeffrey K. Russell, MD; Cindy Spillers, CDE; and The Honorable Charles R. Worley

Dr. Bunting is the manager of community pharmacy clinical services at Mission St. Joseph's Health System. Mr. Garrett is the senior director of medication adherence programs with the American Pharmacists Association Foundation. Dr. Martin is the City of Asheville Medical Director. Mr. Moore is the chief strategic planning and quality improvement officer at Mission St. Joseph's Health System. Dr. Russell is with the Asheville Endocrinology Consultants, P.A. Ms. Spillers is the director of the Diabetes and Health Education Center at Mission St. Joseph's Health System. The Honorable Mr. Worley is the mayor of the City of Asheville, NC.

provide financial incentives to employees for participation, and provide payment to pharmacist care managers.

Employees voluntarily enrolled in the program, attended self-care education classes provided by diabetes educators, and followed up on a regular basis with an assigned pharmacist care manager. The physician was informed of their patient's enrollment and was asked to share their treatment goals. Pharmacists and diabetes educators regularly communicated

Since the original Asheville Project¹ was initiated others have asked what it would take to implement this model in their community and if the model would reproduce the positive outcomes achieved in Asheville.^{2,3} Fortunately, the model is replicable and does produce similar results.⁴

Effective self-management support requires patient-focused collaboration that provides local coordination of patient care resources in a community setting to help patients and their families cope with and meet the challenges of managing and living with chronic disease.⁵ The Asheville Project model is distinguishable from other chronic care systems because it realigns incentives to produce a sustainable model that others can replicate in their communities.

The Genesis of the Asheville Model

In the mid 1990s, North Carolina pharmacy organizations conceived the idea for a community pharmacy-based diabetes care model and recruited an employer willing to pilot the program. Local pharmacists were recruited and trained with the assistance of universities, community physicians, and the local Diabetes Education Center. The employer agreed to offer the program to their employees, pay for self-care education,

with physicians and made recommendations based on the patient's progress and needs. Physicians altered treatment plans based on input from the pharmacist care managers and diabetes educators. The employer was provided reports on clinical and financial outcomes.

Although this project was conceived as a pharmacy initiative primarily involving collaboration with an employer, it quickly led to a linking of multiple resources in the community, including the local hospital system, diabetes and health education center, community pharmacists, self-insured payers, employees with chronic illnesses, diabetes educators, nurse case managers, medical social workers, and physicians. Currently, the



Photo courtesy of Craig Cunningham/ZUMA

Keys to Success in Replicating the Asheville Model:

- Focus on the patient and desired outcomes.
- Include all “stakeholders” in planning and implementation.
- Maintain open communication, sharing information in a timely fashion.
- Ensure that the role of each health care team member is clear.
- Health care team members should be supporting each other—not duplicating efforts.
- Respect, integrity, trust, and excellence of each provider.
- Coordination of patient referrals.
- Education of patients and providers.
- Aligned incentives for seeking and providing care.

program has over 800 patients from 3 employers enrolled in programs for diabetes, asthma, hypertension, and lipid management.

The Asheville Model Concept

Two mental images help visualize the collaborative process and how it works. One illustrates the collaborative process for patient care, and the other is a more global view of how the ideal system should work.

The first picture to describe patient care is that of a 4-legged bar stool (Figure 1). The seat of the stool is the patient. The seat is supported by the stool’s 4 legs: physician, educator, payer, and care manager. And each leg is connected to every other leg by perimeter and diagonal cross-bracing, which represents the collaboration and communication that takes place between all of the health care providers.

The second picture would be to visualize community-based health care as a symphony. In this illustration, the conductor would be the physician, the musical score would be the guidelines from evidence-based medicine, and the players, including the patient, would be everyone who has anything to do with the care of the patient which would lead to beautiful outcomes, beautiful

music. The audience is the payer who receives value for the price of admission.

What Is the Key to Making This Collaborative Community-Based Model Work?

The most important principle of collaboration in management of chronic illnesses like diabetes is to realize the patient is the hub around which everything turns. This is a patient-centric model, not a provider-centric model. The providers need to realize that they each have unique skills that can contribute to better patient outcome, but no one has all the answers for all patients. Traditionally, physicians have been given the responsibility, one could even say burden, of managing patients’ illnesses. Although physicians remain a leader in management of chronic illnesses, the patient is the key to their own success. Patients live with their disease 24 hours a day, 7 days a week.

Roles and Responsibilities of the Stakeholders

Payer

The primary role of the payer is to align incentives for patients and health care providers to encourage patient self-management and collaborative care processes. The payer benefits by receiving a positive return on investment for the incentives that are provided.

Pharmacist

The pharmacist’s function in the care manager/coach’s role is to meet with the patient on a regular basis to review treatment, activity, and nutrition goals that have been negotiated with the

Figure 1

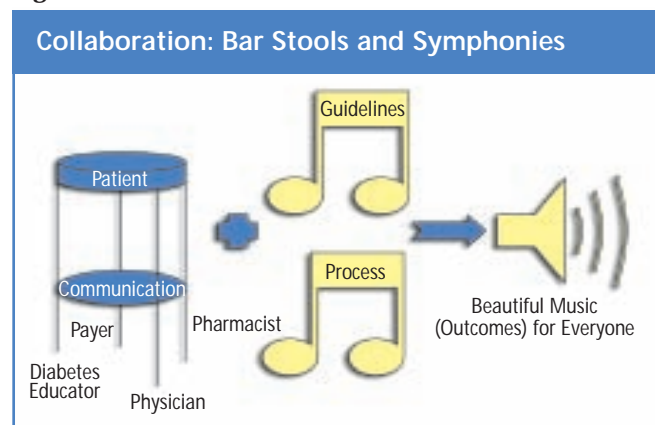




Photo courtesy of Bryan Rimmer/ZUMA

patient by providers; and to assess whether the patient is achieving these goals. The pharmacist also makes recommendations and referrals to the patient's physician and other providers.

Diabetes Educator

Educators fill an important need for expertise in diabetes management, working in collaboration with physicians and other health care providers. The educator is also an excellent resource to utilize in training the pharmacists who are new to disease management to prepare them to take on their role.

Primary Care Physician

Using the analogy of a community symphony, the collaborative model allows the primary care physician to become the conductor of the care model rather than to frantically perform as a one-man band. By effectively utilizing collaborative services from other professionals in the community, the primary care physician can optimize the office visit time to diagnose, treat, and focus on the emotional needs of the patient.

Endocrinologist

Endocrinologists serve as clinical leaders to ensure that best practices are identified and used effectively to achieve optimal patient outcomes. They can also provide initial and periodic consults for individual persons for diabetes care management.

Hospital System

Hospitals frequently have diabetes educators, outpatient facilities, and programs that address self-care issues. The enlightened self-interest of the hospital supports efforts to promote health as a means to manage capacity and human resources needs. Absent efforts to promote health

Photo courtesy of Bryan Rimmer/ZUMA



and disease management would result in service demands that tax the capacity of the organization in terms of human resources and facilities.

Shared Roles

When the patient is being followed long-term by a dietitian or nurse, most of the roles are similar, but the focus is from that individual's discipline. More and more we are seeing the advantage of sharing the responsibility for care management and having the patient spend time with providers from different professional disciplines. It makes sense for a patient who is not on any medications to be followed by a nurse, dietitian, or clinical social worker, for example, and then to be referred to the pharmacist when they are put on medications.

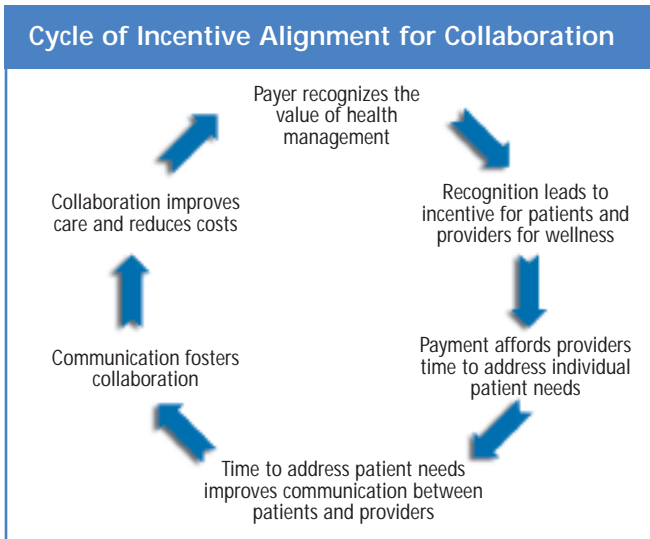
Barriers to Implementing the Asheville Model

- *Time*—Time constraints on each provider create challenges for collaboration. It can feel like there is not enough time to think collaboratively, even though most would philosophically agree that it is needed.
- *Money*—Because time is money, and very few are paying for collaboration, little incentive exists to collaborate.
- *Turf issues*—Professionals can become concerned that another discipline is duplicating or

invading areas of expertise and feel threatened and get defensive when others offer similar care practices.

- *Program development in isolation*—It is important to include all “stakeholders” in the

Figure 2



planning and implementation of a disease management program.

- *Ownership and control*—Individual providers sometimes have the idea that the patient is somehow “mine,” and “I” am in charge.
- *Delays in communication and referral*—It is important to have a central authority, the physician, in charge of decision making, which is facilitated by efficient communication.
- *Lack of recognition for the need for collaboration*—We recognize collaboration when we see it, but it is not inherent in our system. The principles of collaboration are rarely taught, and we have limited examples of collaboration to model.

Strategies to Overcome Barriers to Collaboration

- *Enlist the support of the person with diabetes*—The person with diabetes is the central member of the health care team, and they should be empowered to assist in providing the glue that can bring all members together.
- *Maintain open, ongoing, and reciprocal communication*—Faxing information is an effective way to communicate, especially with physicians and pharmacists. Improve communication through better information systems (computerized medical record, community-wide). Formal written agreements and signed patient consents for sharing of health information are essential to maintain the security and confidentiality of the patient’s health information.

- *Maintain focus*—Each health care provider needs to focus on the areas of diabetes care in which they possess expertise and then refer to other health care team members for support in areas that the other members are more knowledgeable, eg, the pharmacist needs to refer patients who have challenges in the areas of food, nutrition, and meal planning to a dietitian. Provide the appropriate care/intervention at the appropriate place/time.
- *Plan program/protocols and define roles with personal interaction*—Bring the affected health care providers and stakeholders together for meetings on the front of process development to develop systems and procedures.
- *Continually revise/renew processes and procedures*—Look for opportunities to meet periodically to improve the system and implement changes when indicated.
- *Start collaborating even if you are the only one doing it*—Collaboration fosters collaboration. With increasing knowledge of the thoughts of others involved in the patient’s care, we will feel less threatened, less critical, and make more informed decisions.

Aligning the Incentives for Health

Successful collaboration requires recognition that each health care provider has unique skills that patients need. Then each provider needs to focus on what they do well. The ideal model is one in which everyone who comes in contact with a patient is aware of what everyone else who has a stake in the patient’s care is thinking. Sharing of information enhances decision making to support the care of the patient. The key to excellent care is collaboration. The key to collaboration is communication. The key to communication is time. The key to time is payment. And the key to payment is the realization by payers that it costs less to maintain health than it does to fix it when it breaks. Payers are the key to initiating the alignment of incentives to collaboration (Figure 2). When all the health care stakeholders collaborate, we can create a true “health” care system that empowers patients, enables providers to do their best, and reduces costs for payers. ¹⁷

For a list of references, send a stamped, self-addressed envelope to: References Department, Attn. A. Stahl, Pharmacy Times, 241 Forsgate Drive, Jamesburg, NJ 08831; or send an e-mail request to: astahl@ascendmedia.com.

PATIENT CARE CENTER



Expanding the Possibilities: Sites in Six States Demonstrate Benefits of the Asheville Model

Scotti Cohn

Photo courtesy of Bryan Rimmer/ZUMA

In a wide variety of settings and circumstances, the Asheville model continues to expand and flourish—thanks to hard work, a willingness to collaborate, and a belief that pharmacists can make a significant difference in the health of their communities.

Face-to-Face Diabetes Program

Diabetes is one of West Virginia's major health challenges. In April 2004, the West Virginia Public Employees Insurance Agency (PEIA) initiated the Face-to-Face Diabetes Program, a pilot project designed "to improve the health care status of members with diabetes, while reducing their medical costs."

"The Asheville model is a win-win situation with positive outcomes, reduction of days missed, and reduction of unexpected physician and emergency room visits," says Larry Chancey, disease management programs coordinator for PEIA. "It's effective because it's based on the rapport between pharmacists and participants."

Edna Contreras, one of 520 Face-to-Face participants, confirms Chancey's perception. "The pharmacist goes over things very carefully with me and takes his time," she says. Another participant, Charles Peal, comments, "The thing that attracted me was the monetary issue...but it's turned out to be very beneficial in other ways. Face-to-Face has been very helpful in keeping me on track."

"We develop a rapport so they feel confident discussing any issue," says Karen L. Reed, RPh, staff pharmacist for Kmart in Beckley, WV, 55 miles south of Charleston. "Many use food as an antidepressant or have financial concerns. Sometimes you have to address those problems, then move on to the disease state."

REACH—for Good Health

Amy S. Nicholas, PharmD, CDE, and Holly

Divine, PharmD, CGP, CDE, already had a contract with self-insured University of Kentucky (UK) when they heard about the Asheville Project. The 2 women, both clinical professors at the UK College of Pharmacy, contacted the American Pharmacists Association (APhA) Foundation and attended its annual Advanced Practice Institute (API): Diabetes program to learn more.

"We modeled our program after theirs," Divine says, "because it had demonstrated success."

The result was the award-winning Pharmacy REACH program. REACH, which stands for Raising Energy, Awareness, and Campus Health, opened in March 2003.

"We can talk about cost savings and the efficiencies all day," says UK President Lee T. Todd, Jr, PhD. "But without healthier employees, everything we are doing would be for naught."

Nancy E. Kukulinsky, PhD, enrolled in the program when it opened. Kukulinsky, who is director of the administrative core at UK's General Clinical Research Center, has lost 30 pounds and reduced her out-of-pocket medication costs by 60%. "Dr. Amy and Dr. Holly share ideas with me and also converse with my doctor," she says. "It is the best of all worlds."

Carl L. King, a senior engineering associate and program participant, has lost 70 pounds and reduced his medication from 3 pills to 1 pill per day. "I now feel like I have the tools to work on this disease," he says.

PSMP Diabetes: A Five-Site Pilot Program

The first-year data are in and the word is out—the Patient Self-Management Program (PSMP) Diabetes is a success.

PSMP Diabetes was conducted by the APhA Foundation. Patient enrollment began in January 2003. Data collection continued through September 2004. A total of 5 sites were in-

volved—Mohawk Industries Inc in Georgia, VF Corporation in North Carolina, Ohio State University and Kroger in Ohio, and Lakeshore Business Coalition in Wisconsin.

Using the Asheville Project as a model, these 5 sites—all self-insured—offered community pharmacist patient care services to a total of 256 patients with diabetes. The outcomes for the first year offer further validation that pharmacists who receive special training in diabetes management can help improve patients' health, enhance patients' satisfaction with diabetes care, and reduce overall health care costs for people with diabetes.

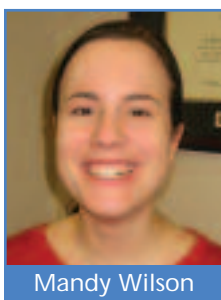
The patients who participated in the 5-site pilot had significant improvement in clinical indicators of diabetes management such as A1C levels (Figure 1), higher rates of self-management (Figures 2 and 3), and increased satisfaction with diabetes care. Employers experienced a decline in mean projected total direct medical costs (Figure 3).

Mohawk Industries Inc, Dublin, Ga—51 patients evaluated

Mohawk Industries is headquartered in Calhoun, Ga. Its Dublin facility, which manufactures and distributes floor coverings, employs approximately 800 people.

"The Asheville model is successful because it is a 'local' program, requiring face-to-face meetings with a counselor," says John Dail, president of J. Arthur Dail Inc. Dail serves as health benefit consultant to Mohawk. "It is also successful because the pharmacist-counselor tends to spend whatever amount of time is needed to effectively monitor compliance with medication, physical exercise plans, and so forth."

Mandy Wilson, PharmD, CDM, works for the Georgia Pharmacists Association, which coordinates the pharmacist network for Mohawk's program. Participating pharmacists include hospital, independent, chain community, and association pharmacists. Wilson has seen dramatic changes in some of the people she counsels. "One very overweight participant got back on track



with healthy eating and exercise and has lost 25 pounds," she says. "It's exciting to see people gain a new sense of control over their lives. Seeing them succeed inspires me to take more responsibility for my own health."

Said Billy Fuqua, a Mohawk Industries employee, "now I understand how you can have diabetes and manage it."

VF Corporation, Greensboro and Wilson, NC—48 patients

VF Corporation manufactures branded apparel such as Lee, Wrangler, and Rustler. More than

Figure 1

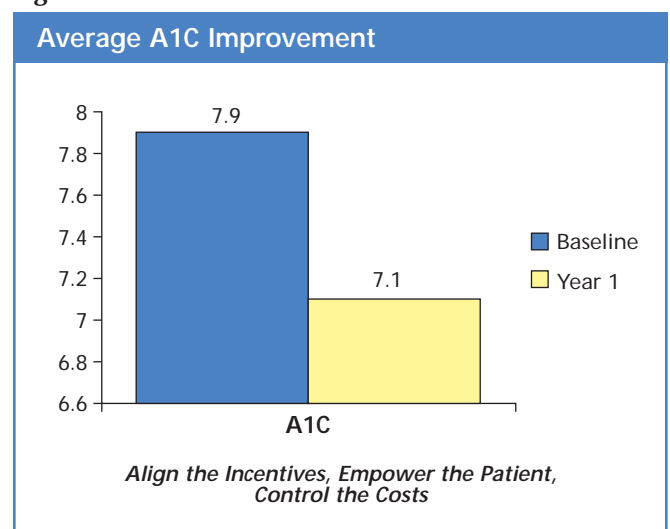
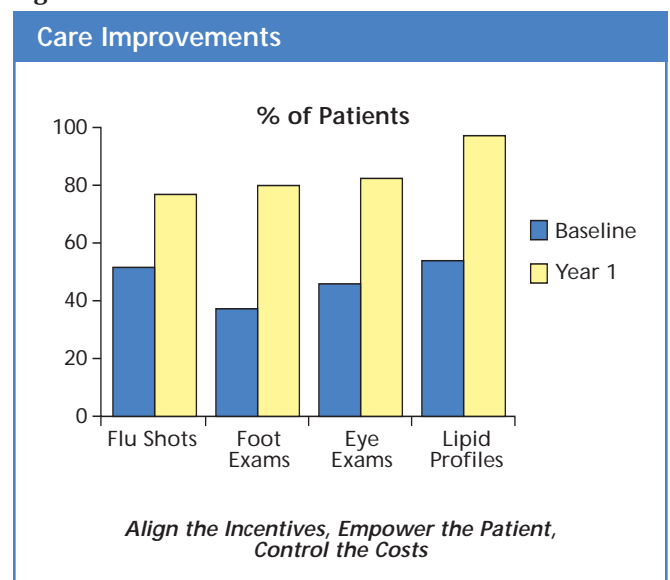


Figure 2





Doug Cornelius

2000 people work in its North Carolina plants.

“The traditional ways of controlling health care costs just weren’t working for us anymore,” says Debbie Arnold, manager of benefits planning for VF. “So we agreed to pilot the Asheville Program.”



Brian Jensen

Linda Goodwin, a credit manager for VF, is glad they did. Diagnosed with type 2 diabetes about 7 years ago, Goodwin joined the program at the outset. “I’ve had an opportunity to learn more about the disease,” she says. “Before, I felt like I was not in

control. Now I set goals and focus on meeting them.”

To J. Frank Burton, RPh, of Burton’s Pharmacy in Greensboro, the program is a natural evolution of the way he has practiced pharmacy his entire career. “It’s that personal knowledge of people and their medical history and family history that makes it work,” he says.

Angela Greene, an in-store account coordinator for VF, knows the benefits of taking care of herself.

Greene has type 1 diabetes, diagnosed when she was a child. “Sometimes you just need someone to be accountable to,” she says. “Frank lets me know if I haven’t done what I need to do.”



Chris Green

Lakeshore Business Coalition, Manitowoc, Wis—52 patients

Six self-insured employers in Manitowoc County, Wis—the Manitowoc Public School District, Franciscan Sisters of Christian Charity Healthcare Ministry, Jagemann Stamping, DOWCO, Formrite, and Lakeside Foods—formed a coalition to participate in the PSMP Diabetes program. They collaborated successfully not only with each other but with 8 pharmacy practices, 18 pharmacists, and 2 competing health networks, each with its own diabetes education center.

“If the program can work here, it can work anywhere!” says Brian Jensen, RPh, FACA, president of Lakeshore Apothacare Inc, doing business as The Medicine Shoppe in Two Rivers. “That was a question we had: Can we replicate what Asheville did? The answer is yes. Our results after 12 to 18 months are remarkably similar to Asheville’s.”

Tom Mueller, human resources director at Jagemann Stamping Company, has personally witnessed the results. “Nine months into the program, one of the participants stood in my doorway with tears in his eyes,” Mueller recalls. “He told me what a life-altering event it had been for him and how grateful he was for the opportunity.” Another employee was significantly overweight when he enrolled and not managing his disease well. “Now every morning he’s in the fitness center on the treadmill,” Mueller declares. “He has lost 50 pounds and feels 100% better.”



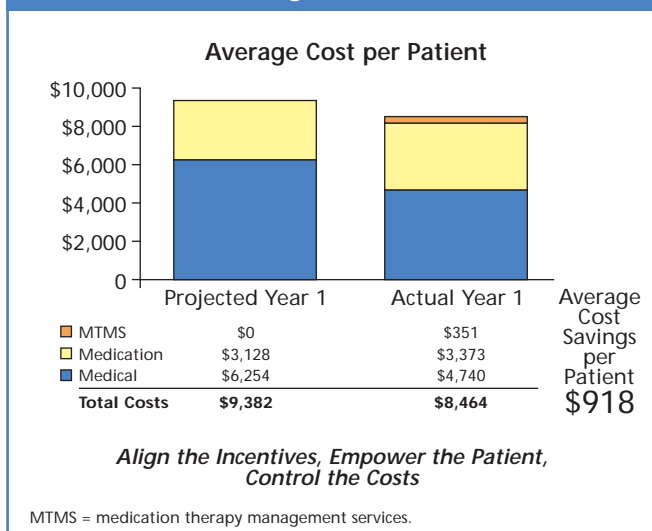
Tom Mueller

Kroger, Columbus, Ohio—24 patients

Headquartered in Cincinnati, Kroger is one of the nation’s largest grocery retailers. Kroger’s Great Lakes Division (Michigan, Ohio, and West

Figure 3

Patient Self-Management Program for Diabetes: First-Year Cost Savings



Virginia) employs more than 28,000 union and management associates.

Kroger in Columbus was involved in the APhA's pilot for PSMP Diabetes. A total of 40 Kroger associates participated.

"Asheville's experience with significant decreases in overall health care costs, decreased time lost, and improved associate relations was very attractive," says Doug Cornelius, RPh, assistant pharmacy merchandiser for The Great Lakes Division. Cornelius admits that getting participants for the program was more difficult than he thought it would be. "People are used to just going along through life," he says. "The idea of taking control and making decisions is foreign and a little scary. That's where the trust with their local pharmacist comes into play. Once you show the patient they can and must be the boss, they run with it."

Pharmacists at Kroger addressed not only diabetes but care issues related to glucose control, skin health, hyperlipidemia, hypertension, immunizations, and weight management. They assisted with referrals to dietitians, podiatrists, dentists, and other diabetes specialists. The result? "Our health metrics definitely show an improvement in overall health for these individuals," says Cornelius.

*Ohio State University, Columbus, Ohio—
81 patients evaluated*

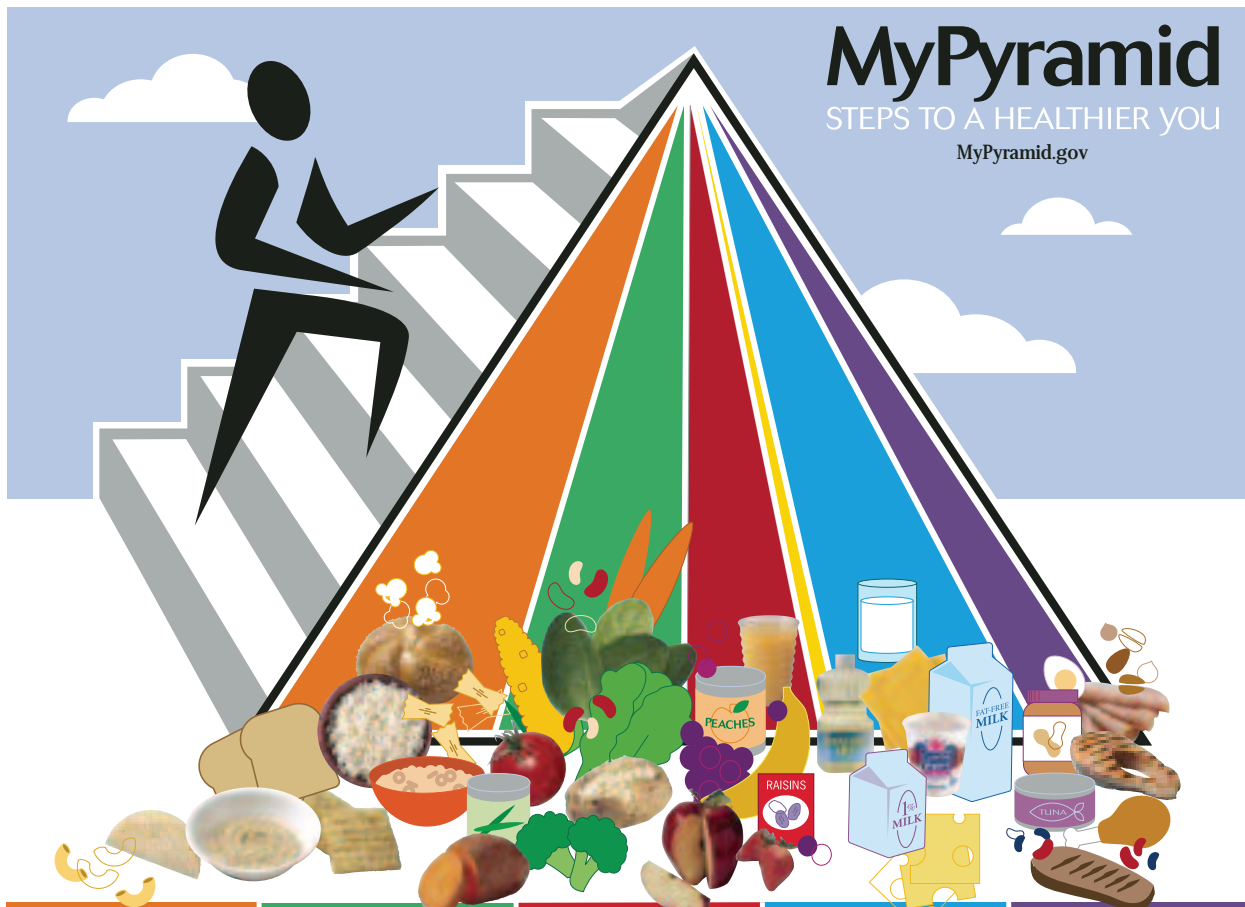
Ohio State University (OSU) Managed Health Care System (MHCS) Inc is charged with managing the health plans offered to employees of the university and their dependents. The health plans cover about 40,000 lives.

"During the time we piloted the program, medication compliance and consistency of care improved," says Lorena Owings, BSN, director of medical services and quality improvement for OSU MHCS. "Most importantly, we saw increased enrollee satisfaction and positive changes in their perception of how they can manage their condition with the help of the program."

Karen Crockett, early childhood specialist at OSU, has type 2 diabetes. "I have a much more thorough understanding of my disease and how I can be actively involved in my treatment and ongoing management," she says. "I can now

make decisions about not just diet, but about stressors, schedules, and activity levels."

"I've seen improvements in clinical markers like hemoglobin A1C," says Chris Green, RPh, PharmD. Green, a clinical pharmacist, works at OSU's University Health Connection. "But I've also seen personal improvement in how people feel about themselves. They are more interested in their care. They know what their goals are and want to meet them. They work harder to meet them because of the extra support available." ^{P7}



MyPyramid
 STEPS TO A HEALTHIER YOU
 MyPyramid.gov

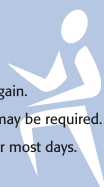
GRAINS Make half your grains whole	VEGETABLES Vary your veggies	FRUITS Focus on fruits	MILK Get your calcium-rich foods	MEAT & BEANS Go lean with protein
Eat at least 3 oz. of whole-grain cereals, breads, crackers, rice, or pasta every day 1 oz. is about 1 slice of bread, about 1 cup of breakfast cereal, or 1/2 cup of cooked rice, cereal, or pasta	Eat more dark-green veggies like broccoli, spinach, and other dark leafy greens Eat more orange vegetables like carrots and sweet potatoes Eat more dry beans and peas like pinto beans, kidney beans, and lentils	Eat a variety of fruit Choose fresh, frozen, canned, or dried fruit Go easy on fruit juices	Go low-fat or fat-free when you choose milk, yogurt, and other milk products If you don't or can't consume milk, choose lactose-free products or other calcium sources such as fortified foods and beverages	Choose low-fat or lean meats and poultry Bake it, broil it, or grill it Vary your protein routine – choose more fish, beans, peas, nuts, and seeds

For a 2,000-calorie diet, you need the amounts below from each food group. To find the amounts that are right for you, go to MyPyramid.gov.

Eat 6 oz. every day	Eat 2 1/2 cups every day	Eat 2 cups every day	Get 3 cups every day; for kids aged 2 to 8, it's 2	Eat 5 1/2 oz. every day
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Find your balance between food and physical activity

- Be sure to stay within your daily calorie needs.
- Be physically active for at least 30 minutes most days of the week.
- About 60 minutes a day of physical activity may be needed to prevent weight gain.
- For sustaining weight loss, at least 60 to 90 minutes a day of physical activity may be required.
- Children and teenagers should be physically active for 60 minutes every day, or most days.



Know the limits on fats, sugars, and salt (sodium)

- Make most of your fat sources from fish, nuts, and vegetable oils.
- Limit solid fats like butter, stick margarine, shortening, and lard, as well as foods that contain these.
- Check the Nutrition Facts label to keep saturated fats, trans fats, and sodium low.
- Choose food and beverages low in added sugars. Added sugars contribute calories with few, if any, nutrients.

Why Implement the Asheville Model?

Scotti Cohn

Photo courtesy of Bryan Rimmer/ZUMA

It is a staggering statistic—people with chronic conditions can account for more than 50% of an employer's health care cost.

Diabetes is one of the worst culprits. According to the American Diabetes Association (ADA), in 2002, diabetes was associated with \$132 billion in medical care and lost wages. Medical care costs alone were \$91.8 billion. The United States spends \$13,242 on each diabetes patient, compared with \$2560 per person for people who do not have diabetes. The ADA also notes that workers with diabetes between the ages of 8 and 64 miss an average of 8.3 days of school/work, compared with 1.7 days for people without diabetes.

Employee absences and productivity issues take a heavy toll on a company's bottom line. In the words of Bonnie Blackley, benefits director for Blue Ridge Paper Products (BRPP) in Canton, NC, "We have to attack this every way we can." BRPP implemented the Asheville Project model at the beginning of 2001. Since then, they have expanded the program to address not only diabetes, but chronic obstructive pulmonary disease, heart failure, hypertension, asthma, and maternity care.

Because It Saves Money

In fact, it is less expensive to keep people healthy than to pay for acute medical services when they become seriously ill. On the surface, it seems like a no-brainer—the investment in medications and medication therapy under a Patient Self-Management Program (PSMP) on one side,

versus the cost of emergency room visits, hospitalizations, and long recovery periods for complications due to untreated disease on the other side. The Asheville model has been shown to produce sustained reductions in actual health care costs for individuals in the program.



Jay N. Scott

The impact of the Asheville model on the members of Manitowoc Health Care Coalition Cooperative is a case in point. Jay N. Scott, CHC, vice president and senior benefits consultant for Associated Financial Group, summarizes, "After 18 months, we've seen an approximate average savings of \$1000 per participant in medical plan costs net of all program expenses."

Employee absences and productivity issues take a heavy toll on a company's bottom line.

Larry Fisher, retired finance director for the City of Asheville, explains what the situation was before the Asheville Project was implemented. "We had employees going to the emergency room for problems related to their chronic illness." Long-time participant Thomas Swafford, firefighter with the City of Asheville, knows how that can happen. Swafford has been diagnosed with asthma, diabetes, high blood pressure, and high cholesterol. "In the long run," he says, "this program saves the insurer money. One trip to the hospital in an ambulance is \$400—and that's not counting what it costs after you get inside the hospital."

The American Pharmacists Association (APhA) Foundation lists the following benefits of PSMP Diabetes: lowers blood sugar levels (A1C), reduces sick days by 50%, improves quality of life, and produces net savings from \$1622 to \$3356 per patient per year based on data from the Asheville Project.

Because It Keeps Employees Healthy

Employees are the backbone of any company, and helping employees and their families become healthy and remain healthy is in keeping with the mission and values of most organizations.

"We operate every day with the mindset that 'Our People Are Great!'" says Doug Cornelius,

RPh, assistant pharmacy merchandiser for the Great Lakes Division of The Kroger Company, “and we want to do what we can to show them that.” Kroger implemented a PSMP Diabetes program in Columbus, Ohio, in 2003. Cornelius likes to talk about associates who, after being in the program for several months, realize they have not called in sick for a long time. Why? “They know how to manage their health!”

As David Westerfield, human relations director at Mohawk Industries Inc in Dublin, Ga, looks back over the years, he remembers the company actually losing some of its employees to diabetes. “And so when you see this total switch,” he says, “and being able to provide an opportunity at a normal lifestyle, one they can enjoy with their families—I think that is the most rewarding thing of all.”

“I’m healthier because of this program,” says Thomas Swafford of Asheville. “And I know that some people couldn’t afford their medicine without it.”

Because It Creates a “Win-Win” Situation for All Stakeholders

Employers and payers win because health-related costs are reduced. These reductions are achieved in many different ways. For example, the City of Asheville found that when absenteeism was lowered, fewer overtime hours were required to cover missed shifts.

Patients win because they become more knowledgeable and better equipped to manage their illness and are therefore able to maintain or improve their level of health. Incentives offered by employers often include lower copays or even complete coverage for prescription medications and supplies associated with the disease.

Pharmacists win because their time and expertise are rewarded financially and through the knowledge that they are helping people achieve a better quality of life.

Physicians and other providers win because the responsibility for patient care and disease management is shared, and they are able to use their specialized knowledge and skills more efficiently and effectively.

Jay Scott with Associated Financial Group notes, “It is truly a ‘win-win’ for all stakeholders. You don’t find many cost containment strategies

that actually provide benefits to health plan members and providers!”

Because the Asheville Model Works

The success of the original Asheville Project, which involved the City of Asheville and Mission Hospitals, has been widely publicized. Now year-1 data is available for 5 new pilot sites that are using the APhA Foundation’s PSMP to focus on diabetes: Healthcare Coalition Cooperative, Manitowoc County, Wis; Mohawk Industries Inc, Dublin, Ga; The Kroger Company, Columbus, Ohio; The Ohio State University, Columbus, Ohio; and VF Corporation, Greensboro, NC.

Lorena Owings, RN, care manager at Ohio State University, summarizes, “It is a patient-centric model which I believe is the core principle of any effective disease management program. It does not, in any way, replace the relationship that a patient has with a primary care provider, but enhances and is adjunctive to it.” ^{PT}



Photo courtesy of Craig Cunningham/ZUMA

Ms. Cohn is a freelance writer who specializes in health care and history and is based in Bloomington, Ill.



Photos courtesy of Brian Strickland/ZUMA, Bryan Rimmer/ZUMA, Craig Cunningham/ZUMA

Why Pharmacists?

Education, training, accessibility, and communication skills are key

Scotti Cohn

Photo courtesy of Bryan Rimmer/ZUMA

Collaboration among providers is essential to the success of any disease state management program. In order to avoid duplication of effort, confusion, and conflict, a health care team needs a point person—someone to coordinate and communicate with everyone involved so that everything comes together for the benefit of the patient. The question is: Who should that point person be?

The pharmacist's qualifications for such a role are rooted in undergraduate and graduate education programs that provide a solid foundation of medical knowledge and expertise. Today, that foundation is broader than ever. "Students are now being taught how to do total management of the patient, not just learning about drugs," notes Dawn Pettus, PharmD, CPP, assistant director of pharmacy education services for the Greensboro Area Health Education Center in North Carolina.

"We have the right background and are willing to go through certification and education," says Beth Greck, PharmD. Greck works at Kerr Drug in Asheville, NC, and serves as pharmacist consultant to Asheville-area participants Blue Ridge Paper Products. "We have a desire to learn, to keep up with what's new."

That desire motivates pharmacists to obtain additional education and training to expand their knowledge base. "All our pharmacists have training in diabetes care through continuing education certificate programs or previous work experience," says Holly Divine, PharmD, CGP, CDE, a clinical professor at the University of Kentucky College of Pharmacy. Along with col-



Beth Greck

league Amy S. Nicholas, PharmD, CDE, Divine administers REACH [Raising Energy, Awareness, and Campus Health], the university's award-winning diabetes program. "We don't assume that being a pharmacist makes you an expert on every disease."

Larry Chancey, disease management program coordinator for West Virginia's Public Employees Insurance Agency (PEIA), observes, "In our everyday dealings with pharmacists, we may forget about the education and training they have. They are now being utilized more and appreciated for the services they can provide." Pharmacists who participate in

West Virginia's "Face-to-Face Diabetes Program" must complete the training program offered by PEIA, or a comparable program.

Jean Johnson, a technical editor at

Ohio State University (OSU), considers pharmacists an "ideal" choice for the role of disease management counselor. Johnson was diagnosed with type 2 diabetes in 1992. She has been participating in a program offered by OSU for a year and a half. Her pharmacist is Marialice Bennett, RPh, FAPhA. "Pharmacists not only have a thorough understanding of disease processes, how medications can affect those processes, and how various medications interact with each other," Johnson says, "but they also—at least in my experience—are highly skilled at clearly and effectively explaining all these things so that suddenly a light bulb goes on, and you think, 'Oh, of course, now I get it!'"

Karen Crockett, an early childhood specialist at OSU, has high praise for the level of expertise her pharmacist brings to the table. Crockett, who was diagnosed with diabetes in 1993 and also has high blood pressure, meets regularly with Jennifer Rodis, PharmD. "[Jennifer] has been an excellent resource regarding my overall health care,"

In addition to education and training, accessibility gives the pharmacist an advantage.

Crockett says. “She is able to counsel me regarding the medications that I take, and also is knowledgeable about other issues, such as foot care, exercise, labels on food products, and stress management.”

In addition to education and training, accessibility gives the pharmacist an advantage. Strong interpersonal skills generate a level of trust and comfort that often leads to improved compliance on the part of a patient.

“A pharmacist can provide consistent, measured feedback, and encourage accountability on the part of the client.”

Andrew Webber, president and chief executive officer of the National Business Coalition on Health (NBCH), sees accessibility as an important component of successful disease state management programs. “By taking advantage of the traffic already going through pharmacies, you add value,” he says. “It makes sense for [pharmacists] to play a role in consumer education and in positively influencing individuals and employees within companies to better manage chronic illness.”

“A pharmacist can provide consistent, measured feedback, and encourage accountability on the part of the client,” says Brian Jensen, RPh, FACA, president of Lakeshore Apothacare Inc, doing business as The Medicine Shoppe in Two Rivers, Wis. Jensen counsels participants in the Lakeshore Diabetes Project. “I see my role as that of a coach, empowering people and holding them accountable—encouraging them if they begin to slip.”



Andrew Webber

Jensen’s approach works well, according to project participant Dale Brassler of Manitowoc, Wis. “Brian is the kind of guy who says ‘I see you’ve got another prescription,’ and then asks how you are doing and how the medication affects you. He



Photo courtesy of Craig Cunningham/ZUMA

motivates me to take a more active interest in what I should be doing to take care of myself.”

“It’s not that pharmacists aren’t busy,” comments Tom Mueller, human resources director for Jagemann Stamping Company, a participant in the Lakeshore Diabetes Project. “But they have taken the time to get educated and to fill that void. They are committed to that role.”

A regular, casual meeting with my pharmacist keeps me on track. It reminds me to do what I am supposed to be doing to take care of myself.

Karen L. Reed, RPh, staff pharmacist for Kmart and member of the Board of Trustees for the American Pharmacists Association (APhA), offers consultations by appointment, “but people can call any time or stop in and speak to me,” she says.

J. Frank Burton, RPh, of Burton’s Pharmacy in Greensboro, NC, works with participants in the disease management program at VF Corporation. A pharmacist for more than 30 years, he has always taken a personal interest in his customers. “I’m used to spending the time it takes to get a point across,” he says. “Pharmacists are in a position to do this more than many other health care professionals.”

His comments ring true for Angela Greene, who works in VF Corporation’s marketing department. Greene was diagnosed with type 1 diabetes at age 8. “Frank knows my goals and what I am doing to manage my diabetes,” she says. “His store is right across the street from where I work, and that’s a blessing to me.”

Larry Fisher, former finance director for the City of Asheville, has been participating in the Asheville Project since its inception in 1996. Along with Risk Manager John Miall Jr and others, Fisher was instrumental in getting the program started in Asheville. Pharmacist Beth Greck advises Larry, now retired, and his wife, Ann, on managing high blood pressure and high chole-





Photo courtesy of Brian Strickland/ZUMA

terol. When asked why a pharmacist makes the best point person for this type of program, Larry Fisher replies, “With pharmacists you have routine, periodic screening by knowledgeable people. A regular, casual meeting with my pharmacist keeps me on track. It reminds me to do what I am supposed to be doing to take care of myself.”

The pharmacist’s ability to interact with other health care professionals—physicians, nurses, diabetes educators, and nutritionists—is also critical. “I can communicate with other health care providers but can also bring it to a level a patient can understand and feel comfortable with,” Karen Reed comments. “I sometimes see myself as a ‘cruise director’ helping them navigate where they need to be in the system.”

“Our purpose is to complement the efforts of other health care professionals, not compete with them,” says Brian Jensen. “In the first six months of our program, we referred 50% of the enrolled patients to CDEs [Certified Diabetes Educators].”

*“Our purpose is to complement
the efforts of other health care
professionals, not compete
with them.”*

Karen Crockett at OSU notes, “Another important role of the pharmacist I’ve been working with involves referrals to other professionals such [as] nutritionists and exercise programs, and she also has routine communication with my physician.”

As health care costs continue to rise in the United States, more employers and payers are seeing the benefit of implementing disease state management programs. They need someone who can serve as coordinator, communicator, educator, motivator, coach—maybe even “cruise director.” Who better to do it than the pharmacist? ^{R7}

Ms. Cohn is a freelance writer who specializes in health care and history and is based in Bloomington, Ill.

Extending the Parameters

Blue Ridge Paper Products takes the Asheville model cross-country

Scotti Cohn

Photo courtesy of Bryan Rimmer/ZUMA

If Blue Ridge Paper Products (BRPP) could have packaged and transported the Asheville Project by truck to its Canton, NC, facility, the trip would have taken about 30 minutes. Canton is just west of Asheville, NC, but the disease management model that proved so successful in Asheville cannot be boxed, bottled, or bundled. It has to be created fresh at each new site, with input and cooperation from local stakeholders. The health needs of the community, employer's financial position, and willingness of providers to collaborate must be considered (see "What It Takes to Replicate the Asheville Project," page 7).

Not surprisingly, it took BRPP months instead of minutes to "transport" the Asheville Project to Canton. Nevertheless, it was time well spent according to company managers—so well spent that they decided to take the model on the road to their plants in 4 other states.

In the Beginning

BRPP, originally Canton Pulp and Paper Mill, was built in 1905. In 1932, Canton Mill housed the largest paper machine in the world. The company is now an employee-owned, self-insured paper and liquid packaging manufacturer with approximately 2100 employees.

Because of the physically dangerous nature of the work, emergency medical technicians (EMTs) are on-site around the clock at BRPP's Canton facility. The decision to implement a disease management program there was made when these EMTs discovered a high incidence of diabetes among employees.

Benefits director Bonnie Blackley had heard of the success of the Asheville Project. She and Jessica Ellis, manager of health services, gathered information and presented it to BRPP management. The program was implemented at BRPP in

January 2001. On-site EMTs were trained to participate as much as possible, and at first pharmacists were not involved. They soon began to play a role, however—visiting employees at the plant and meeting with dependents off-site.

"We knew we would be better able to motivate and incent our employees with an on-site program," said Blackley. "We wanted to make it easy for them to join and participate." Other incentives included waived copays and coverage of many out-of-pocket expenses.

Participants were required to provide certain necessary information, attend a diabetes education program, visit their monitoring specialist monthly, use the monitor and test strips provided by the program, check their hemoglobin A1C and cholesterol levels regularly, and use a specific

pharmacy for their diabetes supplies and prescriptions.

Al Forney works in the waste treatment plant for the mill and the town of Canton. Diagnosed with diabetes in 1997, he joined the program when it was first offered, primarily because of the prescription medication coverage. He soon discovered additional benefits.

"The education required by the program made me feel different about diabetes," he said. "I realized a lot of people had it and were dealing with it successfully. I've had relatives who had to have amputations, and I thought I wouldn't be able to avoid that. Now I've learned how to keep my blood sugar down. I know how important that A1C number is."

Beth Greck, PharmD, visits the Canton plant periodically to conduct medication reviews with participants. She also counsels Asheville Project participants at Kerr Drug in Asheville. Greck likes to talk about the dramatic improvements experienced by one patient in particular. "When I first saw him, he had just finished the diabetes educa-

"We knew we would be better able to motivate and incent our employees with an on-site program."

tion classes. He told me, 'I'm going to do this. I need to take care of myself.' And he did. He applied himself and committed to what he learned. Every time I saw him, he had reached another level. He was exercising every day and enjoying it. He ate well. He lost 100 pounds and came off all his medication for diabetes and high blood pressure."

"An employee will call and say 'I had no clue on how to eat. I've lost 30 pounds since I went through diabetes education,'" comments Jessica Ellis. "They have to tell somebody because they are so proud of the weight loss, or that their A1C is down."

Extending the Parameters South, North, East, and West

BRPP has established similar programs at its mill in Waynesville, NC, and its DairyPak facilities in Georgia, Virginia, Ohio, and Iowa.

In Richmond, Va, BRPP managers got in touch with pharmacists who were already performing diabetes monitoring and education. Michelle Shibley, PharmD, CDE, was ready and waiting for an opportunity to work with an employer. DairyPak in Richmond started its diabetes management program in the summer of 2001. Initially, only 1 employee signed up. After he returned to the plant and

talked to other employees about it, however, 4 more people immediately joined, and the number of participants continues to grow. Similar results have been noted at BRPP's plant in Athens, Ga.

Up in Ohio, Giant Eagle Pharmacy and Ohio Northern University (ONU) in Ada put together what they call "a new model for an old profession." In its search for pharmacists to implement a disease management program at DairyPak in Olmsted Falls, Ohio, BRPP had contacted the Ohio Pharmacists Association. ONU already had a contract with Giant Eagle in the Olmsted Falls area for experiential rotations. It was a perfect match.

David Kisor, PharmD, Marc Sweeney, PharmD, Jeff Allison, PharmD, and John E. Stanovich, assistant dean of Rudolph H. Raab College of Pharmacy were key players for ONU. Representing Giant Eagle Pharmacy were Larry Cost, RPh, regional pharmacy specialist, Jennifer Johnson, PharmD, David Isaacs, RPh, CDE, and Kristian Miley, PharmD, CDE.

In December 2002, employees at DairyPak in Olmsted Falls were screened for blood glucose, cholesterol, weight, and blood pressure. Flu and pneumonia vaccinations were offered. A health risk assessment was done for each employee.

"We then referred patients to their local physician when



appropriate,” says Marc Sweeney, PharmD, of ONU, “and also recommended that patients with diabetes or high blood glucose participate in Giant Eagle’s Diabetes Management Program. Blue Ridge Paper Products paid for these pharmacists’ services.”

BRPP now offers disease management programs for chronic obstructive pulmonary disease, heart failure, hypertension, and asthma.

Monthly follow-up pharmacy care visits were scheduled to perform appropriate tests such as hemoglobin A1C, lipid panel, and cholesterol. During these visits, pharmacists monitored progress and documented outcomes. Patient incentives included copay waivers for medication and supplies, laboratory tests without copays, and free glucose meters.

At a presentation in September 2004, Allison and Miley noted that of the 10 patients included in data collection, 80% completed an eye exam during the year, 80% had a dietary consult, 30% were tested for microalbuminuria, and 30% performed regular foot exams. Health care savings and productivity data were encouraging.

At DairyPak in Clinton, Iowa, health screenings determined that cardiovascular disease was the most significant health problem for employees. Working with Osterhaus Pharmacy in nearby Maquoketa, Iowa, and Outcomes Pharmaceutical Health Care of Des Moines, the company launched a case management program in February 2002. Every 4 to 8 weeks, pharmacists now take blood pressure, pulse, and weight; collect patient information; and identify medication therapy problems. Participants discuss their health goals and their plans to achieve those goals.

BRPP now offers disease management programs not only for diabetes, but for chronic obstructive pulmonary disease, heart failure, hypertension, and asthma, as well as a special program for pregnant participants. About 400 people participate in the programs. The company has experienced “reduced health care costs, weight loss, and employees who are better educated, more productive, and more in control of their disease,” says Bonnie Blackley. To employers considering the Asheville Project model, Blackley advises, “Don’t wait any longer. Every day you wait is lost savings.” ^{PT}

Ms. Cohn is a freelance writer who specializes in health care and history and is based in Bloomington, Ill.



Photo courtesy of Bryan Rimmer/ZUMA

Health Management Resources

Photo courtesy of
Bryan Rimert/ZUMA

Diabetes Support Groups

American Diabetes Association
www.diabetes.org

American Association of Diabetes Educators
www.diabeteseducator.org

Diabetes Action Research and Education Foundation
www.diabetesaction.org

Centers for Disease Control and Prevention
www.cdc.gov/diabetes

National Diabetes Information Clearinghouse
www.diabetes.niddk.nih.gov/

National Diabetes Education Program
www.ndep.nih.gov

National Institute of Diabetes and Digestive and Kidney Diseases
www.niddk.nih.gov

Diabetes Monitor
www.diabetesmonitor.com

Juvenile Diabetes Research Foundation International
www.jdf.org

Diabetes Education and Research Center
www.diabeteseducationandresearchcenter.org

Defeat Diabetes
www.defeatdiabetes.org

Psychiatry Support Groups

American Psychiatric Association
www.psych.org/

National Mental Health Information Center
www.mentalhealth.org/

Depression and Bipolar Support Alliance
www.dbsalliance.org/

National Institute of Mental Health
www.nimh.nih.gov/

National Mental Health Association
www.nmha.org/

Depression.com
www.depression.com/

Cardiology Support Groups

American College of Cardiology
www.acc.org

American Heart Association
www.americanheart.org

National Center for Chronic Disease Prevention and Health Promotion
www.cdc.gov/nccdphp/

National Heart, Lung, & Blood Institute
www.nhlbi.nih.gov/

Women's Health Matters
www.womenshealthmatters.ca

Women's Heart Foundation
www.womensheartfoundation.org/

Obesity Support Groups

American Obesity Association
www.obesity.org/

National Heart, Lung, & Blood Institute
www.nhlbi.nih.gov/

National Institute of Diabetes and Digestive and Kidney Diseases
www.niddk.nih.gov

American Academy of Pediatrics
www.aap.org/obesity/

United States Department of Health & Human Services
www.surgeongeneral.gov/topics/obesity/

Association for Morbid Obesity Support
www.obesityhelp.com/morbidobesity/

Additional copies of **Pharmacy Times—Beyond Asheville** are available on request.
Contact Lisa Russo at lrusso@ascendmedia.com

Pharmaceutical Care for Patients with Diabetes: A Certificate Program in Action

Scotti Cohn

Photo courtesy of Bryan Rimmer/ZUMA

In order to participate in the Face-to-Face Diabetes Program offered by West Virginia's Public Employees Insurance Agency (PEIA), pharmacists must receive specialized training. This training is provided by the West Virginia University (WVU) School of Pharmacy in Charleston, WVa, in conjunction with the American Pharmacists Association (APhA).

"We chose the program developed by the APhA because they have a licensing agreement that allows our faculty to be trained to present the program," said Virginia (Ginger) Scott, PhD, associate professor and director of continuing education at WVU School of Pharmacy. "Four of our faculty members had already gone through the program, so all we had to do was update ourselves on changes. We also added a nutrition workshop."

The WVU School of Pharmacy held its first training session of this type in March 2004, with 23 participants. The April 9-10, 2005, seminar had 21 attendees. At the time this article was written, the sessions for May and June were filling up fast, as each seminar is limited to 50 people. The PEIA seminar includes training for PEIA data entry via the Internet. No continuing education credit is awarded, however, for data entry training.

One of the participants in the April program at WVU was Ron Jones, RPh, a pharmacist at Belington Prescription Center in Belington, WVa. Jones decided to seek certification in diabetes management because of his location in a rural area where individuals have limited access to health care services.

"In a sense, we have to be everything for the community," he said. "When someone who has just been diagnosed with diabetes comes into our store, we need to be prepared to give them basic information and to help them get started on managing their disease."

Having been a pharmacist for over 30 years,

Jones was already familiar with much of the material presented at the seminar. Even so, the various components helped him "put it all together."

Sessions included a self-study review as well as the following topics:

- Medication Management Issues in Diabetes Mellitus—Clinical Review
- Practice Implementation (Pharmacist's Responsibility in Diabetes Care; Conducting Insulin Injection Training; Planning and Implementing Your Program)
- Evaluation and Education Planning
- Documentation and Record Keeping
- Licensing and Compliance
- Marketing
- Billing and Reimbursement
- Becoming a Certified Diabetes Educator
- Other Credentialing Opportunities

A breakout session on Foot Care Inspection Technique Practice was led by Condit Steil, PharmD, CDE, professor of clinical pharmacy at Samford University in Birmingham, Ala. During Steil's session, participants checked each other's feet for injuries, circulation problems, condition of nails (too long, ingrown, or infected), and foot deformities. They tested sensation with a monofilament and checked posterior tibial and dorsalis pedis pulses.

Roger Cole, RPh, conducted a segment on "Glucose Meters: Demonstration and Practice," which included instruction on using different types of glucose monitors, selecting a fingerstick site, fingerstick technique, blood sample collec-



Photo courtesy of Craig Cunningham/ZUMA

tion, and proper procedure for discarding lancet and blood strips.

Betsy Elswick, PharmD, clinical assistant professor at WVU and Rite Aid Shared Faculty, led a workshop called “Insulin Injection Technique Practice and Assessment.” Elswick taught pharmacists how to fill syringes using a sterile technique, select a proper injection site, prepare the site and insulin correctly, insert and withdraw the needle, and dispose of the syringes and needles properly. Pharmacists also practiced injecting themselves using normal saline solution.

“One of the most surprising outcomes of the insulin workshop seemed to be in the pharmacists’ realization that insulin injections are relatively painless and easy to perform,” said Elswick.

In a nutrition workshop, Barbara Smith, RPh, CDE, discussed the Food Pyramid and demonstrated carbohydrate counting and meal preparation using realistic models of food items. Participants then practiced assembling healthy meals. Pharmacists were given an additional assignment of counting carbohydrate content of their meals and testing their blood glucose levels during the evening of day 1.

Participants were required to demonstrate proficiency in each technique covered by the sessions. Although some already knew how to inject insulin, inspect feet, and use a glucose meter, those who were less experienced gained confidence by prac-

ticing their technique among other professionals.

“The program also emphasized communication skills,” said Ron Jones, RPh. “I know from experience how important that is. The other day a woman who had just been diagnosed with diabetes came into the store. I had to spend some time with her, getting her to stop crying, before I could even start talking about what she needed to do to manage her diabetes.”

At the end of the second day of training, participants took a final exam. In addition to information that was presented during the sessions, they received a wealth of resource material to take with them for future reference.

Program goals:

- Provide comprehensive instruction in the pathophysiology of diabetes
- Teach current approaches to the medical management of patients with diabetes
- Introduce pharmacists to their role as a diabetes educator
- Provide pharmacists with information about becoming a Certified Diabetes Educator and about other credentialing opportunities



Photo courtesy of Craig Cunningham/ZUMA

About the Pharmaceutical Care for Patients with Diabetes Program

The original Pharmaceutical Care for Patients with Diabetes program was developed in 1996 by the APhA and the American Association of Diabetes Educators through a grant provided by Pfizer, under the guidance of a panel of nationally recognized experts in diabetes care. The program, which consists of a self-study segment and a 2-day live training session, has been used at various locations and through a number of delivery partners throughout the country. Its focus is to teach pharmacists how to teach patients to manage their own diabetes.

The self-study segment consists of 3 modules covering the disease state and its complications, management and monitoring strategies for diabetes, and components of a focused diabetes education practice. Successful completion is determined by a multiple-choice examination. Pharmacists receive 15 hours of continuing education credit, or 1.5 continuing education units (CEUs).

Following completion of the self-study component, pharmacists attend an intensive 2-day seminar. Hands-on training is provided in patient

assessment and education planning; the demonstration and use of diabetes-specific drug delivery and monitoring devices; communicating with patients, caregivers, and members of the health care team; and setting up a focused diabetes practice. The seminar component offers 12 hours (1.2 CEUs) of credit.

Pharmacists who successfully complete both parts of the program receive a Certificate of Achievement. Continuing education credit for all components of the program is provided by the APhA.

Although cumulative data for the life of the Pharmaceutical Care for Patients with Diabetes program is not readily available, nearly 1000 pharmacy professionals have been trained through the program during the past few years. The program is currently delivered annually at the APhA Annual Meeting and Exposition and through several licensed partners, including the WVU College of Pharmacy. ^{PT}

Ms. Cohn is a freelance writer who specializes in health care and history and is based in Bloomington, Ill.



Photo courtesy of Craig Cunningham/ZUMA

The Ten City Challenge

John P. Miall, Jr, ARM

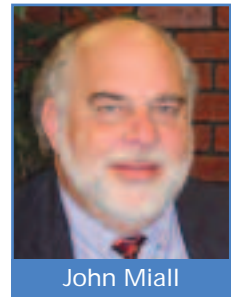
Photo courtesy of
Bryan Rinnert/ZUMA

What began in Asheville nearly 10 years ago has seen tremendous acceptance and is beginning to grow. Payers are desperately seeking solutions to their rising costs of care, but until now, the only options seemed to be cost-shifting to employees in the form of higher deductibles and copays, or denying services altogether. The pharmaceutical care model has shown us that we can continue to provide our employees with a very high level of care and not have to compromise quality nor access, and still get control of our costs.

There really are 3 tests I have learned we need to put all our health care thinking to in this country. First, is this medically sound? If it does not meet this test, we do not need to go any further. Secondly, does what we are doing have the potential to improve peoples' lives? Thirdly, and I contend most importantly, is what we are doing financially sound and delivering the outcome we expect for the money we are spending? So much of health care has been accepted on faith. "It meets the first 2 tests, so that's all we need to know." If we cannot measure the outcomes and the efficacy of what we are doing, however, we should not spend the money on it. With the events in Asheville, for the first time, I saw decisions made based on whether or not what we were doing made any financial impact. That test is one employers are going to demand in the future.

Having recently retired from a 30-year career in local government, I have had an opportunity to reflect a lot about my life and my experiences. Nothing in my life has even been a close second to my experiences as part of the Asheville Project. In my extensive travels around the country, I have seen our program replicated time and again with similar good results. I have seen peoples' lives changed. I have seen entire communities rethink what health care is, or ought to be. I have seen pharmacists embrace this concept as a new part of their practices. I do not think that anything I was a part of touched as many lives in such a positive

way. I am eternally grateful to the physicians, educators, academicians, and pharmacists who worked to make the Asheville Project what it became. It gives me confidence that our best and brightest minds, including those in pharmacy, can rise to the challenge we face in this country in health care.



John Miall

On May 1, 2005, I will embark on a new venture in life. I will become a consultant to the American Pharmacists Association Foundation. With the generous support of the wonderful folks at GlaxoSmithKline (GSK), I will have an opportunity to help grow and expand our model through "The Ten City Challenge" to communities around the country. I cannot think of anything I would rather do with the rest of my professional life than to work with people as talented and dedicated as pharmacists.

Many thanks to all of you, the Foundation, and the staff and leadership within GSK. ^R



Photos courtesy of (left to right):
Brian Strickland/ZUMA,
Bryan Rinnert/ZUMA,
Craig Cunningham/ZUMA

Mr. Miall is president of Miall Consulting and president of Asheville Claims Corp.

BEYOND ASHEVILLE
