Beyond the Manuscript: Developing a Productive Workgroup Within a Community Coalition: Transtheoretical Model Processes, Stages of Change, and Lessons Learned

Shearie Archer, Jennifer Langhinrichsen-Rohling, Emily Blejwas

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Welcome to *Progress in Community Health Partnerships'* latest episode of our Beyond the Manuscript podcast. In each volume of the Journal, the editors select one article for our Beyond the Manuscript post-study interview with the authors. Beyond the Manuscript provides the authors the opportunity to tell listeners what they would want to know about the project beyond what went into the final manuscript.

In this episode of Beyond the Manuscript, Guest Associate Editor, Emily Blejwas, interviews Shearie Archer and Jennifer Langhinrichsen-Rohling, authors of "Developing a Productive Workgroup Within a Community Coalition: Transtheoretical Model Processes, Stages of Change, and Lessons Learned."

Emily Blejwas: This is Emily Blejwas with the Gulf States Health Policy Center in Bayou La Batre, Alabama, and I first just want to extend a huge thanks to Dr. Jennifer Langhinrichsen-Rohling and Ms. Shearie Archer for joining me on the podcast today to talk about their paper. We'll just get started by having each of you introduce yourselves and your organizations. Just tell us a little bit about what kind of work your organization does. Shearie, do you want to start?

Shearie Archer: Sure. My name is Shearie Archer and I'm the executive director of Ozanam Charitable Pharmacy. Ozanam Charitable Pharmacy is a 20-year-old standalone charitable free pharmacy that's located in Mobile, Alabama, and our primary purpose is to provide medication to uninsured individuals in our service area, which includes Mobile, Baldwin, and Escambia counties. We have about 1,671 patients who rely on us to provide them with more than $20 million worth of medication a year, and these are individuals who lack access to basic health care. They can go to the emergency rooms or to the health department, but they often do not have enough money to pay for their medication.

Emily Blejwas: Okay, great. Thank you and Dr. L-R, do you want to tell us about your organization?

Dr. Jennifer L-R: Sure. Hi. I'm Jenny Langhinrichsen-Rohling and I'm a professor of psychology at the University of South Alabama, and I initiated and I'm currently the executive director of the Gulf Coast Behavioral Health and Resiliency Center. Our mission is to improve mental and behavioral health capacity across the Gulf Coast, but particularly in lower Alabama. One of the ways that we're doing that is by working to improve the coordination between what have been considered ancillary services like mental health or pharmacy and primary care, particularly to high-needs patients or patients that typically have experienced low access to health care.

Emily Blejwas: Okay, great. And I just want to talk for a few minutes about the Gulf States Health Policy Center and especially about our health policy coalition, because that is the organizational structure that this group and this research project grew out of. So the Gulf States Health Policy Center is a health policy

research center that aims to improve health outcomes and reduce health disparities in the Gulf States, which include Alabama, Mississippi, Louisiana, Florida, and Texas, and we are led by a partnership of BayouClinic in Bayou La Batre, Alabama, the University of Alabama at Birmingham, and The University of Southern Mississippi.

In addition to our health policy research, we have a health policy coalition that brings together community members, practitioners, and academics from various organizations and disciplines, both within health and without, and outside of the health system. We have over 90 organizations that meet monthly in four locations, and the coalition is also composed of smaller subgroups that self-identified and self-organized around policy focus areas that were important to them. And so both Jenny and Shearie come out of the health literacy policy focus area in the Bayou La Batre coalition group.

So my first question is how was it that all of these people from different disciplines, different organizations, different walks of life coalesced around health literacy, and what was your experience like working with a diverse group around policy and how was it different to work, to be given—so we as the Gulf States Health Policy Center, we gave them a charge which was to design a research project that will inform, help inform policy, so give information to policymakers. How was that experience focused on policy as part of this coalition different than other experiences you've had working in coalitions related to health?

Dr. Jennifer L-R: I'll tackle that question first I guess. I think we had a very charismatic leader in our group who had been a longtime pharmacist practicing in a part of Mobile, Alabama, which is very near Bayou La Batre that is high poverty and has a lot of health disparities. And he was frustrated, I think, in his practice as a pharmacist not being able to practice at the top of his license because of some of the state laws and regulations we have about medication therapy management and collaborative practice, and he saw patients who were on multiple medications from different doctors for the same condition, or were having a side effect from one of their medications, but did not have a primary care provider relationship that they could go back to easily to report on that side effect.

And so he felt very strongly that pharmacists needed to be a part of helping patients understand and be literate about their health conditions and the medications they're taking and the treatment that they're receiving, and that pharmacists really need to be part of integrated health care. So he sort of started that conversation for us.

Emily Blejwas: Okay, great. And when you compare the work that you do as part of this coalition in getting this research study together, getting the resources together, and putting it into practice—and I guess we can go to you first, Shearie, with this one—is this different? I know you participate in a lot of other kinds of groups, coalitions, taskforces. Nonprofit collectives. How was working on policy and health policy and research a different experience for you versus working with groups of nonprofits primarily?

Shearie Archer: Well, you know, first of all I think working with the group, the health literacy group, has been just a phenomenal experience for Ozanam. Our pharmacy is a homegrown pharmacy, and so we started out basically as a mom and pop that's grown to a teaching organization. So having the diverse group of people in this particular workgroup work on policy has helped us to look beyond just providing medication, but doing more within the community because we have those voices from the different backgrounds and skill sets that having us to look at policy, and it's opened new doors for the pharmacy to branch out, to talk with other providers, and to develop or strengthen the policies that we currently

have with the organization, also to bring in other stakeholders to Ozanam to help us to do a better job by providing access to medication to our underserved population.

Emily Blejwas: Okay, great. And let's talk a little bit about that link that you mentioned that was created through this study between Ozanam, which is the charitable pharmacy, and the Mobile County Health Department, which was not necessarily part of the original study design but became kind of an important piece I think of making a policy or practice change to improve—that would ultimately improve health outcomes by improving the communication. What has that been like and how did that come up and why is that important?

Shearie Archer: From Ozanam's standpoint, it opened the doors to communicate for the first time actually directly with providers at the health department who have been sending patients to Ozanam for basically 20 years. So we had an opportunity through this particular workgroup to meet with the providers in one of their provider meetings and explain to them what we're trying to do with the study, and it also gave us an opportunity to learn how much they valued Ozanam as a part of them providing health care to their patients. And as a result of that we are going to attend other provider meetings in the future. So the outcome of that has been a great opportunity for Ozanam to actually build a relationship with those who are providers and sending their patients to the free pharmacy to obtain medication.

Emily Blejwas: Great.

Dr. Jennifer L-R: I think it's been really eye opening as to be part of this coalition and to be discussing what exactly policy is, because at the beginning when we thought about policy we were thinking of it more as something that was operating on the national level or on the state level. And then, through trying to enact things that might be helpful at the state level, we realized that there are policies that are located within the pharmacy, that are located within the health center—there are policies that are located on the university side when you're enacting a research study that can be looked at and changed so that it's more likely that people are going to get better health care.

And one of the policies that we're really looking at is how do we get information from the pharmacy into electronic health records of the federally qualified health center and then responded to in a timely manner so that we can really make sure that all the care providers who are helping the patient who is struggling with uncontrolled diabetes are on the same page and are working with that patient for the same end goal of better health.

Emily Blejwas: And kind of following up with you, Dr. L-R, what was it like for you as an academic researcher to design a study alongside community partners and nonprofit partners? How did that experience differ from designing it just within the university, and did it impact the research design itself to have those voices at the table?

Dr. Jennifer L-R: I think it was essential to have those voices at the table, because the study itself is taking place in the pharmacy. So our partners in the pharmacy said what would work and what would not work, and is this something that we care enough about to even implement and to track and take care of. So, actually, our study involves three different arms. We have what we call a bronze arm, where patients with diabetes receive the meter and the instructions on their use and they get the basic drugstore interaction, so it's essentially treatment as usual. Then they have a silver arm. In the silver arm, they get medication management and educational information. And then they have a gold arm, and in

the gold arm they really get sort of this intense 30-minute encounter with a lot of dialog back with a primary care provider.

And so it's actually a randomized trial and it involves teaching pharmacy students who are becoming pharmacists about different ways of interacting with patients that they have come to their pharmacies. So there's all kinds of pieces involved with this that would not be possible without really active engagement and involvement by our community partners. So yeah, the study really from start to finish is owned by the pharmacy. They report out on it. They conduct it. So it's really very, very different than conceiving something separately at the university and then trying to find a place to enact the research.

Shearie Archer: And what was so beautiful about the whole process is that the work group really took under consideration the capacity of the pharmacy. Did we have enough staff in place? Are we putting additional burden on current staff? How would we implement this? Because we did have to use some of the volunteers and staff of the pharmacy to make this study happen. And from the looks of it, to me it's been seamless. It's worked in with our workflow. The students during their rotations are really learning so much. These are things that they would not be able to get in a classroom.

So it's two parts to that. They're learning about clinical trials, they're learning about how to take care of underserved patients, and they're practicing one of the newest parts of pharmacy which is medication therapy management, otherwise called MTM, providing them with 45-minute sessions to help the patient to understand their disease state and their medication and how to inject their insulin if they're on a pen or if they have needles. So, so much goes into that, and all of this has been a part of this study that has really added to what we offer as a nonprofit pharmacy.

Emily Blejwas: That's great. What do you think—you know, getting a bunch of people together from different organizations and tasking them with creating a health policy research project is a pretty big ask, and not something that happens every day in the world of nonprofits. So what do you think were the factors that enabled your group to accomplish something like this, creating this study and getting IRB [institutional review board approval] for the study and organizing it at the pharmacy and then actually implementing the study. What made you able to pull it off?

Shearie Archer: I'll take that first. I think the group actually had a shared interest, and I think our overall focus was actually to provide positive health outcomes for our patients. You know, I think that was the primary focus and we worked from there. And I do not know if you agree, but it's just been a great experience for Ozanam in that aspect.

Dr. Jennifer L-R: I agree completely. I think we share that desire to help underserved patients and to improve the health outcomes of our community as a group, and I also think that we were pretty remarkable in the sense that many people in the group really think that Ozanam itself, having a charitable pharmacy is a really important aspect of better health care for a community. And so I've seen a variety of different members of the group try to find ways to find other resources for the pharmacy. I mean just a few days ago a different member of the group said, "I think I've found a way to get some ways to do A1C levels that might be very inexpensive." So I think we were not competing for resources. Instead, we were looking for resources to support a very valuable entity in our community.

Emily Blejwas: Okay. Great. Another thing that strikes me about this article is that you're all able to come sort of behind this policy and you're all motivated by producing positive health outcomes for patients, especially for

underserved patients. But can you talk a little bit about the different group members and sort of their background or their role at their organization and what specifically they're motivated by? Because it strikes me that even though you're kind of coming together for this collective goal, everyone seems to be coming at it from a little bit different perspective.

Dr. Jennifer L-R: I would agree with that. I think obviously we have some pharmacists that are part of the group that are—but they're actually interested in a variety of things. One is the policy of collaborative care and medication therapy management, so at that policy level they're active at the state level. But some of the pharmacists or another one of the pharmacists in the group I think is really very patient centered, but also really excited about the opportunity to train and teach up-and-coming pharmacists. So we have a partnership with Auburn University and we have pharmacy students rotating through the clinic, and each of them, as we said, is sort of becoming, having to get their human subjects certificates and learn about the study and be part of the study and kind of connect to the study really at a pretty high level. And so that's—even among the pharmacists there are different motivations and different aspects of things that they're finding exciting.

And then we have, you know, a person who does policy. It's not policy related to pharmacy, but he sort of understands the kinds of evidence you need to change policy. Myself, I'm a psychologist, but I'm very interested in integrated health care, so that motivates me. We have a postdoctoral fellow who was really excited about doing essentially a clinical trial. We have a person who's a nurse practitioner who's very energetic and very well-connected to pharmacy care, but also is an expert in diabetes, which is the health target that we took on. We obviously have the director of the charitable pharmacy, so there was buy-in at the organization level. So, you know, everybody had a piece of the puzzle and it was really only through sort of a synergistic activity that we could even attempt this or enact this.

I do think one thing that helped move us forward rather quickly was that we, as a group, realized that we needed to meet outside of the larger coalition meeting to move the ball forward more quickly, and so after, I think really after about the first year of the broader coalition we started meeting outside the group pretty much monthly, and we have, you know, a high level of e-mail exchange, electronic exchange among the group about our projects and activities. So we really developed our own group identity among the different partners.

Emily Blejwas: You've been able to get this research project designed and implemented. If a group came to you or if a university or just a community partner came to you from a different city in the Gulf States and said—or even outside of the Gulf States—and said, "We really want to get a collective together to push health policy forward to be able to give some research outcomes to these policymakers so that they can improve policy or put policy in place where it does not exist, and we want to do it in partnership with academia and community," what advice would you give? What part of this process do you think is really important to your success, and what would you tell another group that was trying to do something similar?

Shearie Archer: Well, that's actually happening right now as we speak. I just joined a new organization that's being formed for a charitable pharmacy—charitablepharmacy.org. I'm on the board of that organization, and we're in the process of building a toolkit because smaller licensed pharmacies, standalone free pharmacies, are popping up all over the country and different models of what we are. We are a standalone pharmacy. There's hospital charitable pharmacies that are popping up. And just different—there are pharmacies, charitable pharmacies within a clinic. And so we're building a toolkit, and part of that toolkit is going to be collaboration.

And in that collaboration section we'll be able to show how academia and charitable pharmacies work together, that is, through getting students, through clinical trials, through different aspects, but definitely we're encouraging the newest of the licensed free pharmacies to do that on the front end of building that pharmacy. And so I'm excited that this will be coming out at the national conference in October, our entire toolkit, and a lot of what's going to be placed into that toolkit will be what we learned along the way during this collaboration. And so I'm excited about it.

Emily Blejwas: That's great news. I had not heard that. That is exciting. How about you, Dr. L-R?

Dr. Jennifer L-R: I was just going to say I think part of the way we've approached writing the article, the behind the scenes that we're talking about is that we were really interested in that change process, like how do you get people from precontemplation, where they do not really even know that there is policy around pharmacy integration or sharing of information between pharmacy and primary care providers, through understanding that, to planning something ambitious like we did, to taking action, and then ultimately maintaining this workgroup in ways to continue developing and participating across time. You know, what are those processes? And so we kind of relied on some literature around change processes, but to me part of it is really about that empowering the group to think that we can do this, and the empowerment came by sheer like force of will, to a certain extent, but also I think because we really had some early successes.

So one lesson learned, I would say, is that your group needs to have some early outcomes and successes because that sort of gives you legs to stand on, and it just happened for us that we had a chance to write an article about pharmacy work. And so we wrote a very early article together about what was known about the collaborative care model and pharmacy role in it, and we got that published and that was the very first publication that our community pharmacist, who was kind of seen as our group leader, had had. And so that was a really good win for the academic kind of practitioner group, that he could see the benefit of having a document that he could use to disseminate and that gave him some standing to be able to have conversations at the state level that he wanted to have.

So we tried to use all the things that we had at hand to give our group the best possibility of success all the way along, and kind of celebrate those milestones. Because we're still waiting for our study to finish. Obviously, you know, it took a long time to get IRB approval to launch the study. Our goal is to have 60 patients enrolled with approximately 20 in each of our three arms, and as of right now we have about 40 of those 60 patients. So we're about two-thirds of the way through. The research endeavor is a slow process. I think that one of the challenges for bringing academia into a community focused workgroup is that our timeline is often sort of a slower timeline than practice-oriented individuals are used to.

Emily Blejwas: Great. My last question is, personally having watched this coalition develop from its inception, I know that one of the things that we struggled with early on was encouraging members to make that mind shift from thinking about programmatic solutions to thinking about policy solutions. Was there any sort of a-ha moment or any factor that you can think of when you think back to your involvement with the coalition where you saw yourself or another member sort of understand kind of why policy is important or why we're doing policy versus focusing on programmatic solutions? Was there a moment

where you kind of saw that shift take place? And maybe it's incremental, but that's something that's a little bit different about what we do as a coalition.

Shearie Archer: My a-ha moment is that I have to think outside of the organization more often in terms of how we are affecting policy in other entities, like the hospital systems. So it actually encouraged me to join a transitional care team, which is similar to what we're doing without the research study, in developing a better policy between us and the emergency rooms at the various hospital systems. I felt that looking at how we can impact change here and develop policy here, we can do it also outside of the organization as well, and that's well on its way. We will be certifying the various emergency rooms on March second to certify patients so that they'll understand that Ozanam should not be their policy of the first line of providing medication to the patient because there's a barrier between us and the patient, which is that the patient has to be certified, that they should as a policy provide medication to that patient first and then send the patient to Ozanam. So we're trying educate the hospital systems better and to build a policy of how to communicate with us.

Emily Blejwas: Okay, great.

Dr. Jennifer L-R: I think there have been multiple a-ha moments actually, and we have revisited this conversation many times. I'm a clinical psychologist and I think our group tends to sit at the level of, "We want these patients to be in better health and get the care they receive." So we have a very cohesive vision of the bottom of the hill, the downstream. And so the policy focus kept forcing us to sort of pivot from that point and look upstream and say, okay, how is that more likely if these two entities are communicating more effectively? So yes, our patients are going to do better when there's better communication between the pharmacy and the primary care provider. How can we make that happen? Okay, we need to have both a sustainable channel of information sharing, which would involve the electronic health records, so we need a pathway for that, a facilitation for that.

We also need to actually have that communication, probably in person, on a regular basis with the providers at the federally qualified health center. How do we get in on that meeting? What do we do for that? Okay, that needs to maybe have some payment for it. How does that happen? So once you start looking upstream—and there were just multiple times in different meetings where we would sort of look up and go, "What are the barriers to having this come down so that our patient gets the care they deserve? Which of those barriers can we tackle at a system level?" And for me the a-ha moment was that policy also involves like policies that organizations have around workflow and around communication and around provider meetings, that those policies also impact patient health.

Emily Blejwas: Okay. We're out of time. I just want to thank you both so much for taking the time to talk about this article. We're really thrilled that it's a part of the journal. And thank you so much for your time.

Dr. Jennifer L-R: Nice talking with you.

Shearie Archer: Thank you.

Dr. Jennifer L-R: Thank you, Emily. Bye, Shearie.

Shearie Archer: Thank you, Emily. Bye. Bye, Jennifer.