CSHP SEMINAR 2016
TRANSITIONS IN PHARMACY
DISNEYLAND® RESORT • OCTOBER 27th – 30th
Addressing Health Equity in Pharmacy Practice

Annet Arakelian, PharmD, FCSHP, CPHQ
Director, Pharmacy Quality & Medication Safety

Abir Makarem, PharmD
Project Manager, Outpatient Pharmacy Clinical Services

Kaiser Permanente
Southern California Region
October 29, 2016
Disclosure

Speakers have no conflicts to disclose.
Learning Objectives

1. Define key terms associated with health equity
2. Discuss the National efforts to address health disparities
3. Demonstrate how to advance health equity goals within pharmacy practice across the continuum of care
4. Explain how to access and use resources for addressing health disparities.
Test Questions

1-Equitable care is providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.
   A: True
   B: False

2-Recommended strategies for a pharmacy health-system in closing the healthcare disparity gap include:
   A-Awareness of the existence of health and health care disparities
   B-Effective communication to build trust and improve connections between patients and health care providers,
   C-Provision of culturally competent care and services,
   D- All the above,

3-Elements of a culturally tailored pharmacy consult include:
   A-Building trust and connections through acceptance of the individual and the culture
   B-Assessing language preference and utilizing qualified interpreters
   C- All of the Above
The Black-White Health Gap

Estimated incidence of selected diseases, by race and most recent year

- **Childhood (2-19 year-olds) obesity rate per 100, 2011-2012**
  - White: 14.1
  - Black: 20.2

- **Infant mortality rate per 1,000 live births, 2010**
  - White: 5.18
  - Black: 11.46

- **Childhood asthma rate per 1,000, 2013**
  - White: 6.5
  - Black: 10.7

- **Breast cancer (female) mortality rate per 100,000, 2006-2010**
  - White: 22.7
  - Black: 30.8

- **Adult HIV infection diagnosis rate per 100,000, 2010**
  - White: 9.1
  - Black: 84

Notes: All rates are for black and white non-Hispanic populations, except HIV diagnosis rate. Breast cancer mortality rates for whites exclude deaths from D.C., North Dakota, and South Carolina.

Source: Centers for Disease Control and Prevention

THE HUFFINGTON POST
Health Disparities: A barrier to high quality health care

Table 1. Unresolved Health Care Disparities from Healthy People 2000

<table>
<thead>
<tr>
<th>Racial Group</th>
<th>Unresolved Disparity</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Indian and Alaska Natives</td>
<td>Increased rates of diabetes-related deaths and end-stage renal disease</td>
</tr>
<tr>
<td>Asian Americans</td>
<td>Exhibited increased rates of tuberculosis</td>
</tr>
<tr>
<td>African Americans</td>
<td>Continue to have health care gaps with increased diabetes-related deaths or amputations, maternal mortality, and fetal alcohol syndrome</td>
</tr>
<tr>
<td>Hispanics</td>
<td>Unable to decrease adolescent pregnancy rates or increase high school completion rates</td>
</tr>
</tbody>
</table>

What is equity?
Equitable care is

“providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status”.
Six key areas of quality of healthcare are needed to be monitored.

(Acronym: STEEP)
Framework for Quality: Six Areas of IOM Report

Six key areas of quality of healthcare are needed to be monitored.

*(Acronym: STEEP)*
Institute of Medicine (IOM) Unequal Treatment (2002): Recommendations

- Increase public and provider awareness of disparities
- Change financial incentives to improve quality, decrease fragmentation of care
- Ensure provider supply, reduce barriers and promote quality evidence-based practice
- Promote civil rights enforcement
The Patient Protection and Affordable Care Act (PPACA) mandated the establishment of a National Strategy for Quality Improvement in Health Care (the National Quality Strategy, or NQS), as part of the goal of increasing access to high-quality, affordable health care for all Americans.

- NQS pursues three broad aims that guide local, state and national efforts:
  - Better Care
  - Healthy People/Healthy Communities
  - Affordable Care

- In 2015, NQS combined with National Healthcare Quality and Disparities Report due to complementary roles in improving health and health care quality for all Americans.
National Quality Strategy’s six priorities

1. Patient Safety
2. Person- and Family-centered Care
3. Care Coordination
4. Effective Prevention and Treatment
5. Healthy Living
6. Care Affordability
1. Patient Safety: Making care safer by reducing harm caused in the delivery of care
Patient Safety Disparities

- Uncommon
- More than 70% of racial, ethnic, and income-related contracts did not indicate a disparity
- If present at baseline, only about 30% disparities grew smaller
- Identifying new disparities in areas that had none before
- Disparities in patient safety have not been well studied
- One example, adults age 65+ on potentially high risk medications

Note: For this measure, lower rates are better. Prescription medications received include all prescribed medications initially purchased or otherwise obtained as any refills. White and Black are non-Hispanic. Hispanic includes all races. For more information on inappropriate medications, see The American Geriatrics Society 2012 Beers Criteria Update Expert Panel. American Geriatrics Society updated Beers Criteria for potentially inappropriate medication use in older adults. J Am Geriatr Soc 2012 Apr;60(4):616-31.
2. Person- and Family-Centered Care: Ensuring that each person and family is engaged as partners in their care

- Person- and family-centered care measures:
  - Communication: doctor’s office, hospital, and home health care
  - Engagement in decision-making
  - End-of-life care

Adults with a usual source of care whose health providers sometimes or never asked for the patient’s help to make treatment decisions, by insurance (ages 18-64) and education, 2002-2012

Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 2002-2012.
Notes: Less than high school refers to fewer than 12 years of education; high school graduate, 12 years of education; and any college, more than 12 years of education.
3. Care Coordination: *Promoting effective communication and coordination of care*

Care Coordination: People who report that their usual source of care usually asks about prescription medications and treatments from other doctors, by age and income, 2002-2013
4. Effective Prevention and Treatment:
Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease
Admissions with chronic obstructive pulmonary disease or asthma per 100,000 population, age 40 and over, by sex, 2005-2012, and by race/ethnicity, 2012


Note: White, Black, and API are non-Hispanic. Hispanic includes all races.
Adults age 40 and over with diagnosed diabetes with hemoglobin A1c and blood pressure under control, by race/ethnicity, 2003-2006, 2007-2010, and 2011-2012


Denominator: Civilian noninstitutionalized population with diagnosed diabetes, age 40 and over.

Note: Age adjusted to the 2000 U.S. standard population using two age groups: 40-59 and 60 and over. White and Black are non-Hispanic. Mexican American includes all races.
5. **Healthy Living:** Working with communities to promote wide use of best practices to enable healthy living

- Many illnesses associated with chronic conditions are related to unhealthy lifestyle behaviors, environmental hazards, and poor social supports.

- Prevention strategies – increase access to effective clinical preventive services, promote community interventions, and healthy lifestyles.
6. Care Affordability: Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models

- In 2014, Annual health and health care expenditures in the US reached $3 trillion and accounted for 17.5% GDP
- Estimate that 30% of health care spending produces little net value. These include unnecessary services, excess administrative costs, and inefficient delivery
- Increasing costs in hospital, physician office visit, and prescription care observed
Pharmacists’ role in reducing disparities based on three principles

1. All patients have a right to high quality care

2. Medication-use practices should reflect knowledge of, sensitivity to, and for the race and culture of the patient, and

3. Health-system pharmacists have a vital role to play in eliminating racial and ethnic disparities in health care.
Recommended strategies for a pharmacy health-system in closing the healthcare disparity gap:

- Collection of self-reported REAL (Race, Ethnicity and Language), gender, age, etc., and monitoring of data on health disparities
- Awareness of the existence of health and health care disparities
- Provision of culturally competent care and services
- Effective communication to build trust and improve connections between patients and health care providers
- Creation of a more diverse health care work force
- Multidisciplinary teams and evidence-based guidelines
- Conducting research activities to evaluate strategies to address disparities in health care

## Research opportunities

### Table 1. Characteristics of Articles Included in Analysis of Pharmacotherapeutic Disparities

<table>
<thead>
<tr>
<th>Clinical Content Area</th>
<th>No. Articles</th>
<th>No. (%) Articles Examining Specific Basis of Disparity</th>
<th>No. (%) Articles Demonstrating Disparity</th>
<th>Fraction (%) Disparity-Demonstrating Articles Showing Specific Type of Disparity</th>
<th>Waiting Time to Receipt of Drug</th>
<th>Type of Health Outcome Most Frequently Reported</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
<td>34</td>
<td>4 (12)</td>
<td>13 (38)</td>
<td>33 (97)</td>
<td>23 (68)</td>
<td>20/23 (87)</td>
</tr>
<tr>
<td>Cardiovascular disease</td>
<td>63</td>
<td>25 (40)</td>
<td>20 (32)</td>
<td>50 (79)</td>
<td>43 (68)</td>
<td>36/43 (84)</td>
</tr>
<tr>
<td>Diabetes mellitus</td>
<td>12</td>
<td>2 (15)</td>
<td>9 (69)</td>
<td>10 (91)</td>
<td>6 (50)</td>
<td>2/6 (33)</td>
</tr>
<tr>
<td>HIV infection</td>
<td>33</td>
<td>20 (61)</td>
<td>11 (33)</td>
<td>27 (82)</td>
<td>29 (88)</td>
<td>25/29 (86)</td>
</tr>
<tr>
<td>Mental health</td>
<td>90</td>
<td>31 (34)</td>
<td>32 (36)</td>
<td>83 (92)</td>
<td>79 (88)</td>
<td>57/79 (72)</td>
</tr>
<tr>
<td>Oncology</td>
<td>23</td>
<td>1 (4)</td>
<td>4 (17)</td>
<td>22 (96)</td>
<td>18 (78)</td>
<td>8/18 (44)</td>
</tr>
<tr>
<td>Osteoporosis</td>
<td>4</td>
<td>0</td>
<td>1 (25)</td>
<td>4 (100)</td>
<td>4 (100)</td>
<td>4/4 (100)</td>
</tr>
<tr>
<td>Pain control or palliative care</td>
<td>51</td>
<td>22 (43)</td>
<td>27 (53)</td>
<td>43 (84)</td>
<td>37 (73)</td>
<td>22/37 (59)</td>
</tr>
<tr>
<td>Parkinson's disease</td>
<td>1</td>
<td>1 (100)</td>
<td>1 (100)</td>
<td>1 (100)</td>
<td>1 (100)</td>
<td>1/1 (100)</td>
</tr>
<tr>
<td>Total</td>
<td>311</td>
<td>105 (34)</td>
<td>118 (38)</td>
<td>273 (88)</td>
<td>240 (77)</td>
<td>175/240 (73)</td>
</tr>
</tbody>
</table>

*LDL-C = low-density-lipoprotein cholesterol concentration, BP = blood pressure.

Case Study
Disparity in adherence to chronic medications ~ 45%-50%

Role to the Outpatient Pharmacist
Evaluation of an Outpatient Pharmacy Clinical Services Program on Adherence and Clinical Outcomes Among Patients with Diabetes and/or Coronary Artery Disease

• Face to face outpatient pharmacist consults resulted in significant increases in adherence for diabetes patients, decreases in A1c and LDL levels, lower disease-specific hospital admissions and reduced lengths of stay.

• By engaging non-adherent patients to restart their DM or lipid medications during a face-to-face consult, the OPCS pharmacist was able to influence and improve medication adherence and clinical outcomes, particularly among patients with diabetes. A positive ROI was demonstrated.

Every pharmacy visit is an opportunity to improve outcomes

Non-adherent members identified during any outpatient pharmacy visit

Pharmacists provide face-to-face BSMART** adherence consult during Rx pick-up

Pharmacist apply a culturally tailored BSMART ** consult

**BSMART = Barriers, Solutions, Motivation, Adherence tools, Relationship and Triage. A consultation strategy for talking with patients about their medications and identifying and addressing any barriers which might result in medication non-adherence.
The BSMART Consultation

**B** Barriers: identify barriers and assess readiness to change

**S** Solutions: provide solutions to adherence challenges

**M** Motivation: help patients to help themselves

**A** Adherence Tools: provide tools and tips to keep patients on track

**R** Relationships: identify roles of health care team members

**T** Triage: direct patients to other resources in the broader health care system

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3034468/
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2911835/
Cultural Tailoring of the BSMART Consult

“the development of intervention strategies, messages and materials to conform with specific cultural characteristics”

The KP national Equitable Care Health Outcomes (ECHO) Program
Pasick, R., D’Onofrio, C., Otero-Sabogal, R., Similarities and Differences Across Cultures: Questions to Inform a Third Generation for Health Promotion Research, Health Education Quarterly. Vol. 23 (Supplement): S142-S161 (December 1996)
The Four Habits model

Emphasizes the vital skills of listening and demonstrating empathy by

- Investing in the beginning
- Eliciting the patient’s perspective
- Demonstrating empathy
- Investing in the end

The KP national Equitable Care Health Outcomes (ECHO) Program
Pasick, R., D’Onofrio, C., Otero-Sabogal, R., Similarities and Differences Across Cultures: Questions to Inform a Third Generation for Health Promotion Research, Health Education Quarterly. Vol. 23 (Supplement): S142-S161 [December 1996]
The AIDET® communication model includes five steps in a communication framework:

- Acknowledge
- Introduce
- Duration
- Explanation
- Thank you

The five steps help to decrease patient anxiety, to build trust and increase compliance, resulting in improved health outcomes and patient satisfaction.

The KP national Equitable Care Health Outcomes (ECHO) Program
Pasick, R., D’Onofrio, C., Otero-Sabogal, R., Similarities and Differences Across Cultures: Questions to Inform a Third Generation for Health Promotion Research, Health Education Quarterly. Vol. 23 (Supplement): S142-S161 (December 1996)
Culturally Tailored BSMART Consult

In collaboration with the KP national Equitable Care Health Outcomes (ECHO) Program
Culturally Tailored BSMART for Black members

- Building trust is important for every encounter
- Address the patient with formal titles (Mr., Mrs) - to convey respect for the patient and any family members brought to the consultation
- Avoid appearing rushed - which may be viewed as discriminatory
- Do not use “try this medication” - due to cultural fears related to experimentation
- Include family members in consultation, if patient allows - family members play an important part in the patient’s medication adherence.
- Assess language preference and utilize certified interpreters, not family members

Disclaimer: Culturally tailored B-SMART recommendations are excerpts from more detailed communication guides and are intended to provide a basic generalization of the Hispanic and black populations to gain global understanding of the cultural preferences and health beliefs. They are not intended to promote stereotyping of individuals or groups. Healthcare providers must focus on patient-centered care to better understand the unique needs of individuals, while taking the cultural background into consideration. Hispanic and all patients must be assessed for language preference. Certified interpretation is required for LEP patients.
Culturally Tailored BSMART for Hispanic members

- Build connections through acceptance of the individual and the culture
- Introduce yourself as a pharmacist—Hispanic patients hold the physician and other health care providers with high esteem
- Include immediate or extended family members in consultation, if patient allows—family members play an important part in the patient’s medication adherence.
- Assess language preference and utilize certified interpreters, not family members
- Encourage to ask questions—about third of Hispanic patients leave their appointments with unanswered questions

Disclaimer: Culturally tailored B-SMART recommendations are excerpts from more detailed communication guides and are intended to provide basic generalization of the Hispanic and black populations to gain global understanding of the cultural preferences and health beliefs. They are not intended to promote stereotyping of individuals or groups. Healthcare providers must focus on patient-centered care to better understand the unique needs of individuals, while taking the cultural background into consideration. Hispanic and all patients must be assessed for language preference. Certified interpretation is required for LEP patients.
<table>
<thead>
<tr>
<th>Resources</th>
<th>Web address</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency for Healthcare Research and Quality</td>
<td><a href="http://www.ahrq.gov">www.ahrq.gov</a></td>
<td>Includes tools ranging from training programs for low health literacy, cultural competency, and research on diversity, equitable care</td>
</tr>
<tr>
<td>Think Cultural Health</td>
<td><a href="http://www.thinkculturalhealth.hhs.gov">www.thinkculturalhealth.hhs.gov</a></td>
<td>Clearinghouse of programs and resources such as e-learning, articles, etc. Source for National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (the National CLAS Standards)</td>
</tr>
<tr>
<td>National Center for Health Statistics</td>
<td><a href="http://www.cdc.gov/nchs">www.cdc.gov/nchs</a></td>
<td>State and federal database with health and delivery statistics including ethnicity, age, gender, and others</td>
</tr>
<tr>
<td>American Association of Colleges of Pharmacy</td>
<td><a href="http://www.aacp.org">www.aacp.org</a></td>
<td>Curricular resource center has materials for underserved populations, including cultural competence resources</td>
</tr>
</tbody>
</table>
1- Equitable care is providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.
   A: True
   B: False

2- Recommended strategies for a pharmacy health-system in closing the healthcare disparity gap include:
   A- Awareness of the existence of health and health care disparities
   B- Effective communication to build trust and improve connections between patients and health care providers,
   C- Provision of culturally competent care and services,
   D- All the above

3- Elements of a culturally tailored pharmacy consult include:
   A- Building trust and connections through acceptance of the individual and the culture
   B- Assessing language preference and utilizing qualified interpreters
   C- All of the Above
Key references:
(additional available upon request)


Hall-Lipsy EA, Chisholm-Burns M. Pharmacotherapeutic disparities: Racial, ethnic, and sex variations in medication treatment. AJHP 2010; 67:462-8

ASHP Statement on the Health-System Pharmacist’s Role in National Health Care Quality Initiatives.


Bodenheimer, T., Building Teams in Primary Care, [www.chcf.org](http://www.chcf.org), accessed, July 2016


Session Code:

1. Write down the course code. Space has been provided in the daily program-at-a-glance sections of your program book.

2. To claim credit: Go to www.cshp.org/cpe before December 1, 2016.