Addressing Health Equity Gaps: A Call to Action for JCPP

Lakesha M. Butler, PharmD

Dr. Lakesha Butler, LLC “Disrupting the Status Quo”- CEO/Founder

September 25, 2024

4 years ago on June 5, 2020…

National Pharmacy Organizations Unite to Take a Stand Against Racial Injustice

The recent deaths of George Floyd, Breonna Taylor, Ahmaud Arbery, and too many others have ignited strong emotions and continue to shed a glaring light on the day-to-day experiences of Black Americans. Sadly, racism and discrimination are a thread that has been woven into the fabric of this country for far too long.

Adding to the challenges of the global pandemic of COVID-19, which disproportionately impact communities of color, there is a greater public health crisis plaguing our country: racism and discrimination. People of color and other marginalized groups experience a continuum of systemic racism, discrimination, and injustices that result in ongoing health inequities created by numerous factors impacting social determinants of health.

As pharmacists, we took an oath that includes, as its first statement, "I will consider the welfare of humanity and relief of suffering my primary concerns." Humanity includes all people, and we have the responsibility in this country to care for those who are disproportionately suffering. As health care professionals, we are trained to provide the best care to all and to "advocate for change that improves patient care." Advocating against racism, all forms of discrimination and injustice can improve patient care. This is an urgent priority.

- We, as a profession, stand in unity to advocate for the dismantling of systems that have historically marginalized and oppressed Black Americans in this country.
- We stand and advocate against police brutality and law enforcement misconduct.
- We advocate for measures that eliminate inequities resulting from racism and discrimination in every facet of our profession, including patient care, pharmacist and pharmacy technician continuing education, student pharmacist education, workplace practices, pharmacy school admissions, leadership opportunities, and organizational policies.
- We advocate for health equity in marginalized communities to eliminate disproportionate health outcomes.

The time is now to engage in intentional dialogue and action. All forms of racism, discrimination, and injustice are unacceptable. We must all listen, learn, and collectively address this crisis directly. We encourage self and team accountability for upholding actions and social justice to bring forth peace and healing in our communities. The profession of pharmacy, represented by the organizations signed onto this statement, will begin actions to ensure that the care provided by pharmacists and within pharmacies upholds the highest standards. These actions include but are not limited to—

1. Working together to provide opportunities to address health care disparities and strengthen affected communities.
2. Providing pharmacist, student pharmacist, and pharmacy technician education on social injustices and systematic challenges impacting health care.
3. Delivering strategies that focus on change through communications, partnerships, and solutions to address health care disparities.
4. Continuing dialogue among pharmacy organizations and stakeholders to identify and implement change.

Let us work together now to weave new threads that embrace our diversity, honor our humanity, and support people of color and any marginalized populations for the benefit and promotion of current and future generations.

PHARMACY ORGANIZATIONS UNITE TO TAKE A STAND AGAINST RACIAL INJUSTICE

Lakesha M. Butler, PharmD, BCPS
President, National Pharmaceutical Association

Scott Knoer, MS, PharmD, FASHP
Executive Vice President and CEO
American Pharmacists Association (APhA)

Paul W. Abramowitz, PharmD, Sc.D. (Hon.), FASHP
Chief Executive Officer, ASHP
American Society of Health-System Pharmacists (ASHP)

Rebecca P. Snead, RPh, CAE, FAPhA
Executive Vice President/CEO
National Alliance of State Pharmacy Associations

Stacy Sochacki
Interim Executive Director
Hematology/Oncology Pharmacy Association (HOPA)

Lemrey "Al" Carter, PharmD, MS., RPh
Executive Director/Secretary
National Association of Boards of Pharmacy

B. Douglas Hoey, RPh, MBA
Chief Executive Officer
National Community Pharmacists Association (NCPA)

Chad Worz, PharmD, BCGP
Chief Executive
American Society of Consultant Pharmacists (ASCP)

Lucinda L. Maine, PhD, RPh
Executive Vice President and CEO
American Association of Colleges of Pharmacy (AACP)

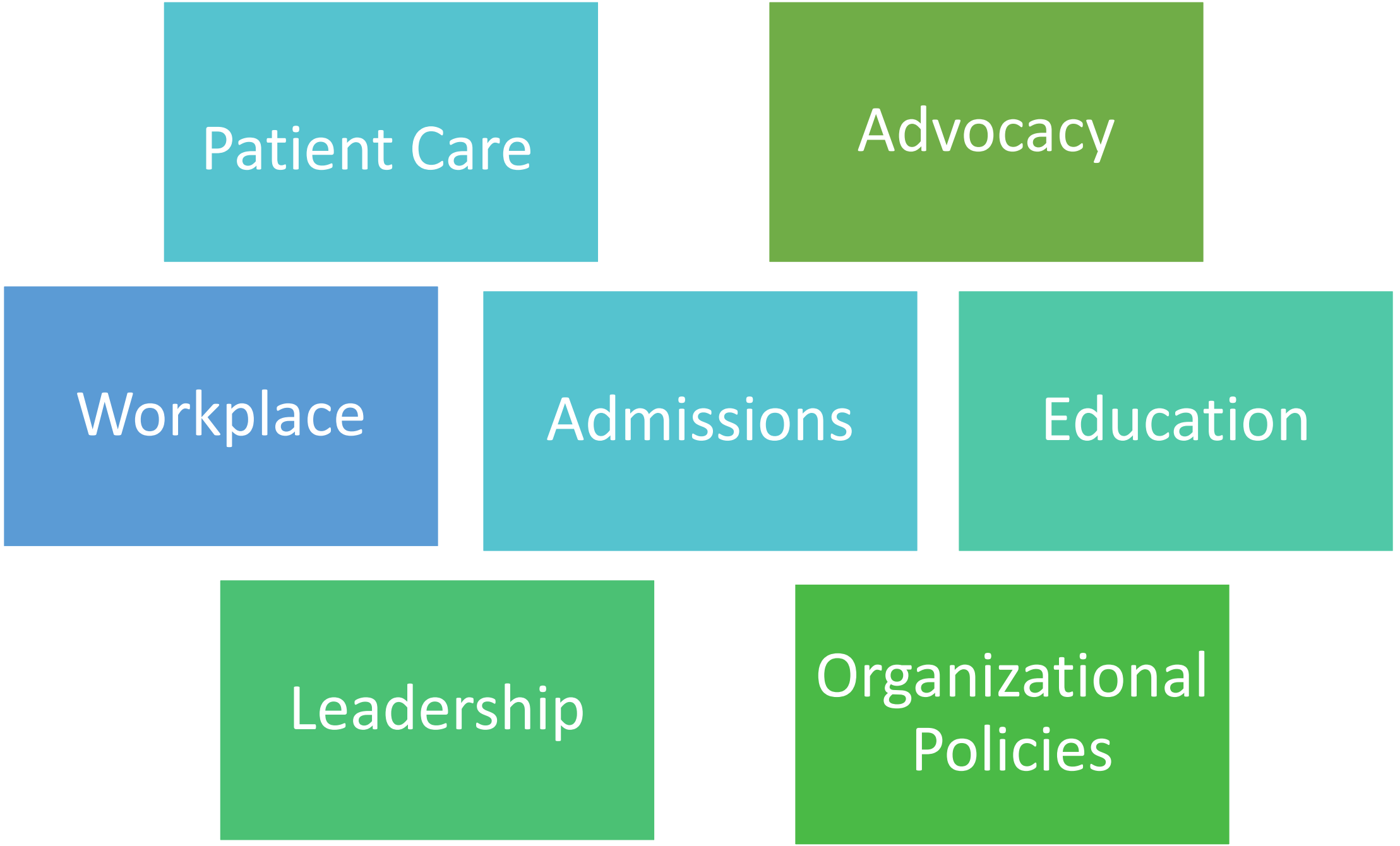
Michael S. Maddux, Pharm.D., FCCP
Executive Director
American College of Clinical Pharmacy

Susan Bartlemay, RPh, FACA, FAPhA
Executive Vice President and CEO
American College of Apothecaries

Susan A. Cantrell
Chief Executive Officer
Academy of Managed Care Pharmacy

Brenda Schimenti
Executive Director
College of Psychiatric and Neurologic Pharmacists

Jan Engle, PharmD, PhD (HON), FAPhA, FCCP, FNAP
Executive Director
Accreditation Council for Pharmacy Education (ACPE)


Patient Care
Advocacy
Workplace
Admissions
Education
Leadership
Organizational Policies

What progress has your organizations made individually and collectively?

Reflection and Discussion

How satisfied are you with the progress?

Scale of 0 (not satisfied at all) to 5 (completely satisfied)

“Health care organizations that prioritize decreasing health disparities must be prepared to make health equity a priority at all levels of the organization and profoundly alter the system that is producing inequitable results.”

Wyatt R, Laderman M, Botwinick L, Mate K, Whittington J. Achieving Health Equity: A Guide for Health Care Organizations. IHI White Paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2016. (Available at ihi.org)

Health Disparity Root Causes

Systemic difference in quality-of-care: Public vs Private

Lack of diverse workforce in healthcare sector

Discrimination

Economic instability

Limited access to care

Structural/systemic racism

Implicit biases

Time restraints

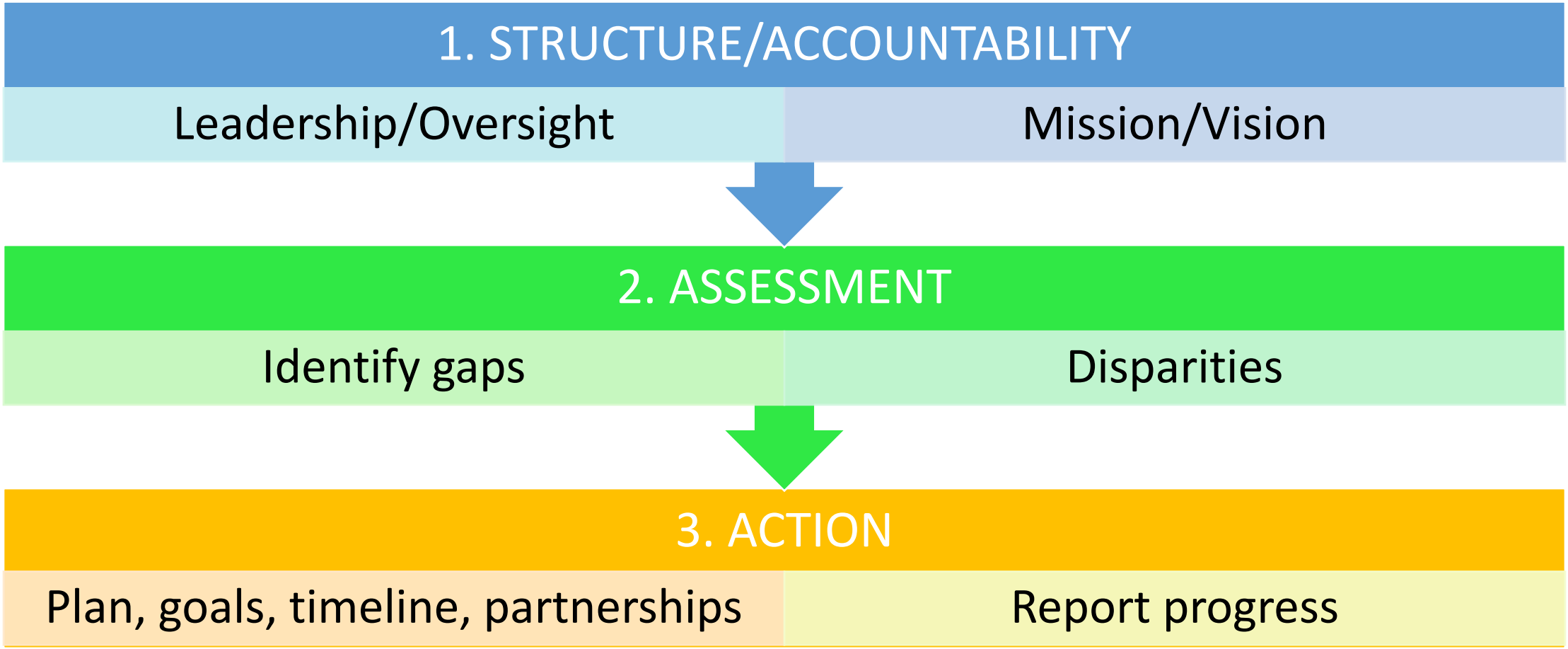
Social Determinants of Health

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment	Housing	Literacy	Hunger	Social integration	Health coverage
Income	Transportation	Language	Access to healthy options	Support systems	Provider availability
Expenses	Safety	Early childhood education		Community engagement	Provider linguistic and cultural competency
Debt	Parks	Vocational training		Discrimination	Quality of care
Medical bills	Playgrounds	Higher education			
Support	Walkability				

Health Outcomes

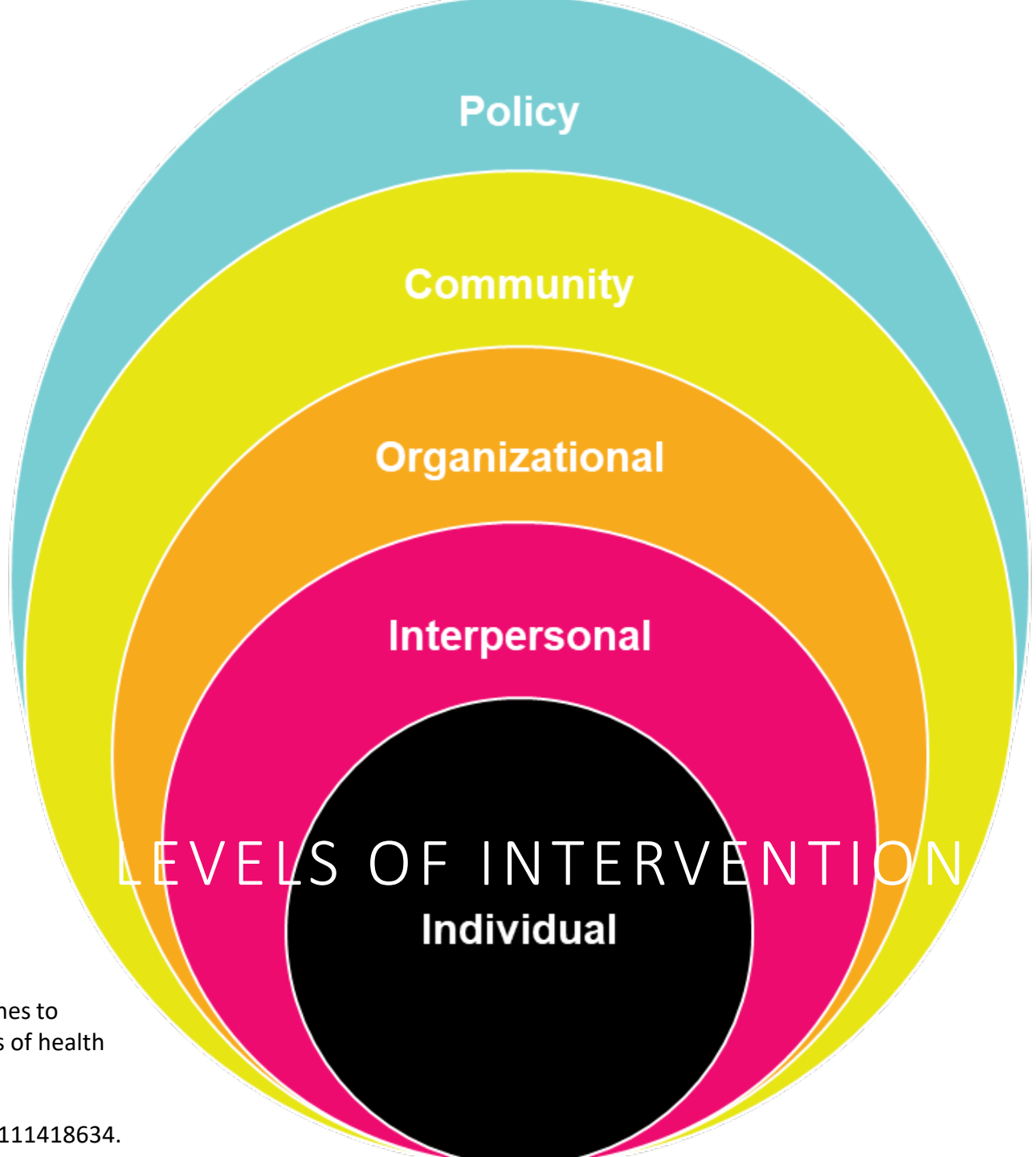
Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

Road map to addressing health equity within organizations



Steps to address health equity:

- Begin improvement work by considering the needs and issues faced by populations experiencing worse health outcomes
- When devising improvement strategies, take into consideration the resources available to particular populations such as where they live, their financial situation, level of education, and access to transportation
- Establish trust with affected communities by investing in their development and advancement
- Advocate for and provide services and resources in communities with greatest need



LEVELS OF INTERVENTION

Golden SD, Earp JL. Socioecological approaches to individuals and their contexts: : twenty years of health education and behavioral health promotion interventions. *Health Education & Behavior*. 2012;39(3):364–372. doi: 10.1177/1090198111418634.

Advocacy- Policies to address health disparities

- HR 1770 Equitable Community Access to Pharmacist Services Act (ECAPS)
- Implicit bias training requirement for state pharmacy licensure
- Pharmacy and Medically Underserved Areas Enhancement Act
- Access to Birth Control Act
- Workforce and pharmacy academic practices

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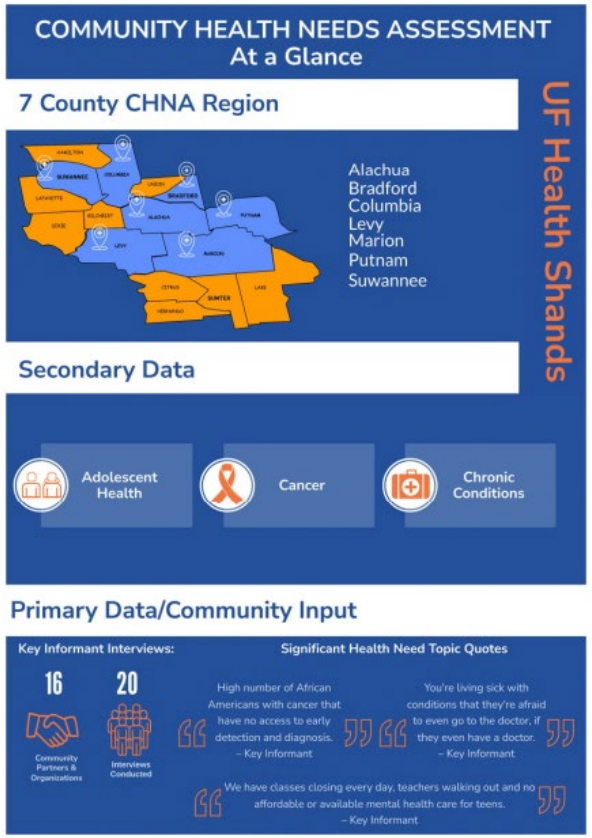
Advancing Health Care Equity, Together

Our vision is that all people always experience safe, high-quality health care. Learn all the ways we empower providers like you to move from intention to action in improving health care equity.

https://www.jointcommission.org/our-priorities/health-care-equity/

Community Health Needs Assessment & Implementation Plan

CHNA At a Glance



Goal:

Enhance chronic care management and reduce emergency room visits for adults in the communit focusing on COPD, heart failure, diabetes, and hypertension, through targeted strategies and initiatives.

Objective:

Achieve a reduction in readmissions related to COPD and heart failure and establish an operationa urgent care center in East Gainesville.

Strategies:

1. Improve chronic care management of COPD, heart failure and hypertension within primar care to reduce readmissions.
   Increase community awareness and education about chronic conditions.
2. Collaborate with home visiting programs to prevent unnecessary readmissions.
3. Implement Transition of Care Management groups for follow-up and support.
4. Engage with Health Street for community outreach and resource alignment.
5. Increase the completion of transitional care (hospital discharge) outreach phone calls and in a timely manner, within 2 business days and 14 days respectfully.

Programs/Activities:

1. Establish an urgent care center in East Gainesville to provide acute medical services to ass addressing exacerbations of chronic medical conditions in a timely manner
2. Conduct community engagement activities, forums, and meetings to involve the communit the development of the urgent care center.
3. Develop community health programs addressing topics such as stress management, diabet awareness, tobacco cessation, and nutrition.
4. Collaborate with local stakeholders, including the health department and community organizations, to build infrastructure and support for community health initiatives.

Collaboration Partners:

1. Home visiting programs and community health workers for coordinated care and prevention of readmissions.
2. Health Street and Mobile Outreach Clinic for community outreach and resource alignment.
3. Local stakeholders, including the health department and community organizations, for infrastructure and support.
4. Primary care physicians, hospital staff, home care providers and community health workers for collaborative patient care.
5. UF cardiology and pulmonary specialists

Resources:

1. Human resources for community engagement activities and Transition of Care Management groups.
2. Educational materials and programs for chronic condition awareness and management.
3. Support from local stakeholders and community organizations for infrastructure development.

Target Population:

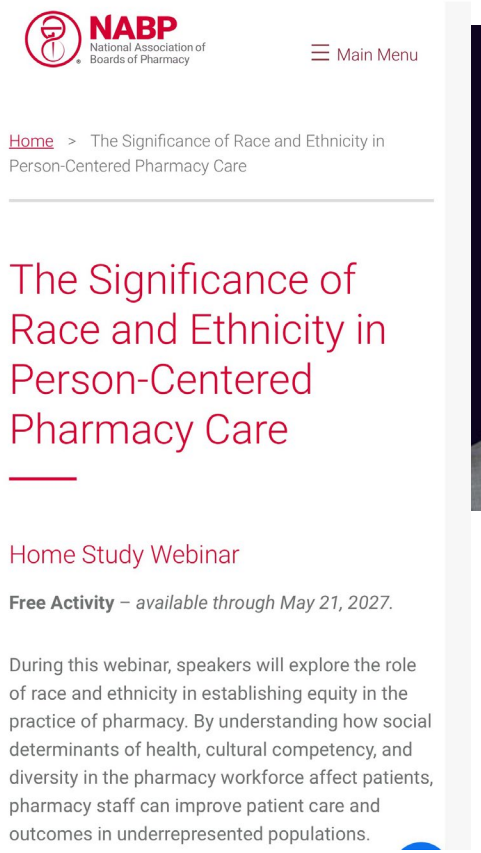
Adults in the community, especially those with COPD, heart failure, diabetes, and hypertension, focusing on East Gainesville.

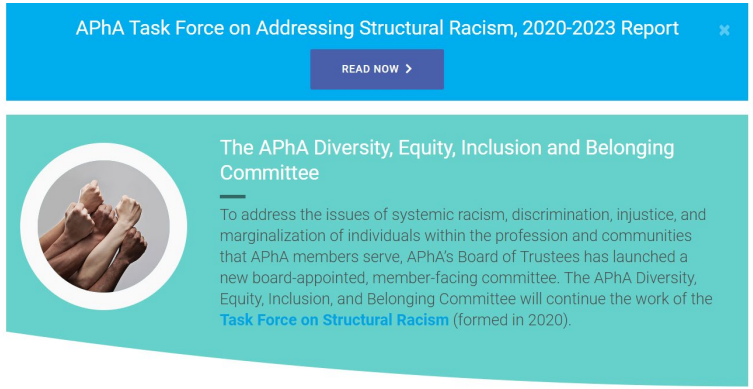
Anticipated Outcomes:

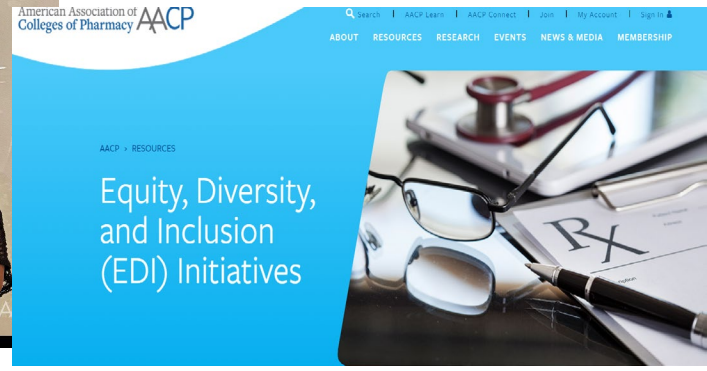
1. Reduction in hospital readmissions and ED admissions related to COPD and heart failure.
2. Reduction in hypertensive urgency and emergency diagnoses in ED
3. Reduction in hyperglycemia-related and hypo-glycemia-related ED visits
4. Establishment of an operational urgent care center in East Gainesville.
5. Improved community awareness and education on chronic conditions.
6. Enhanced collaboration and coordination among healthcare providers for comprehensive patient care.

Best Practices

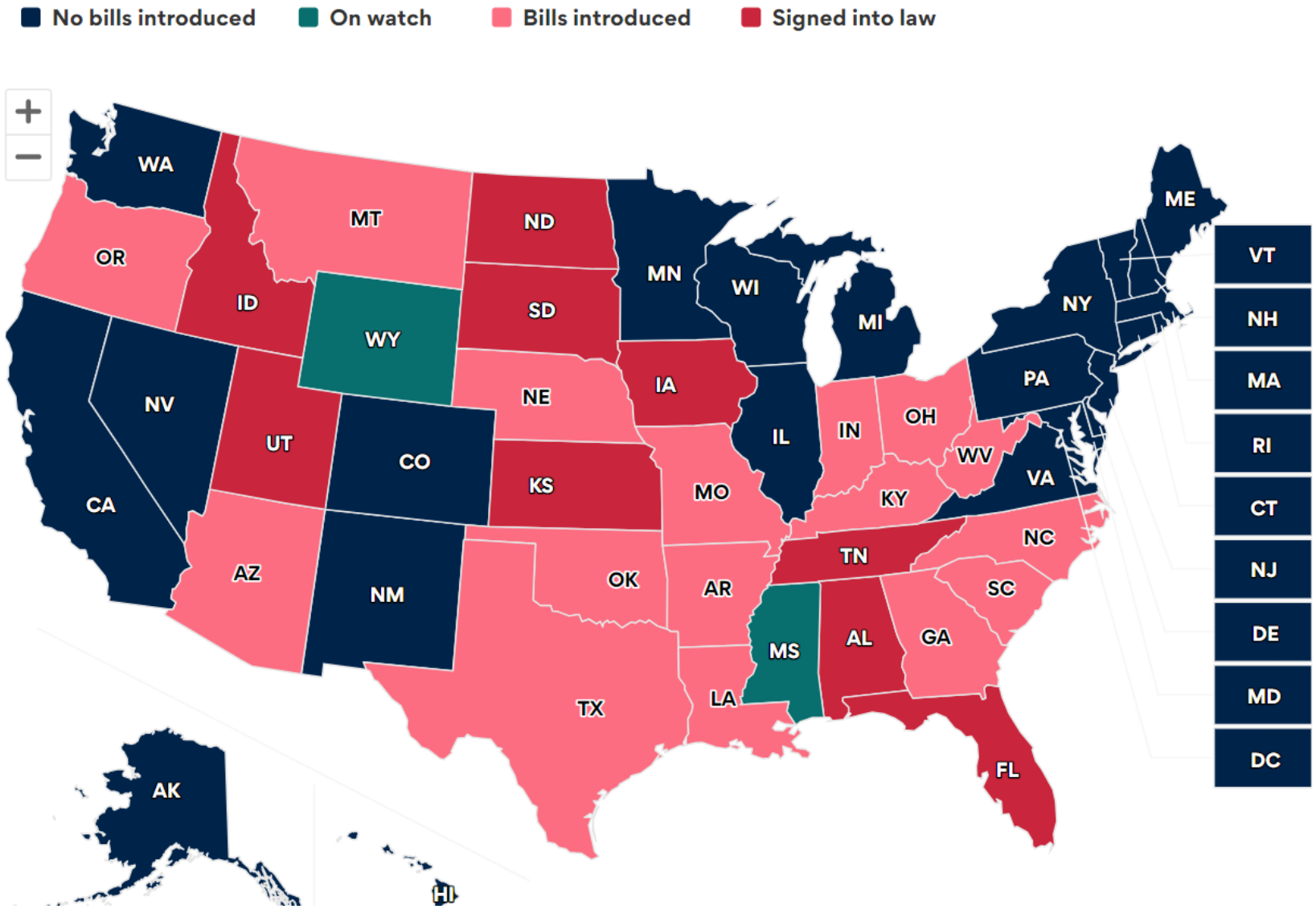
- Visible on website
- Focused area at conferences
- Leadership representation
- Intentional education
- Think tanks
- Partnership with organizations
- Infrastructure (policies, practices)
- Annual report/dashboard







DEI Landscape Changes



https://www.bestcolleges.com/news/anti-dei-legislation-tracker/

Equality is everyone getting a pair of shoes.

Diversity is everyone getting a different type of shoe.

Equity is everyone getting a pair of shoes that fits.

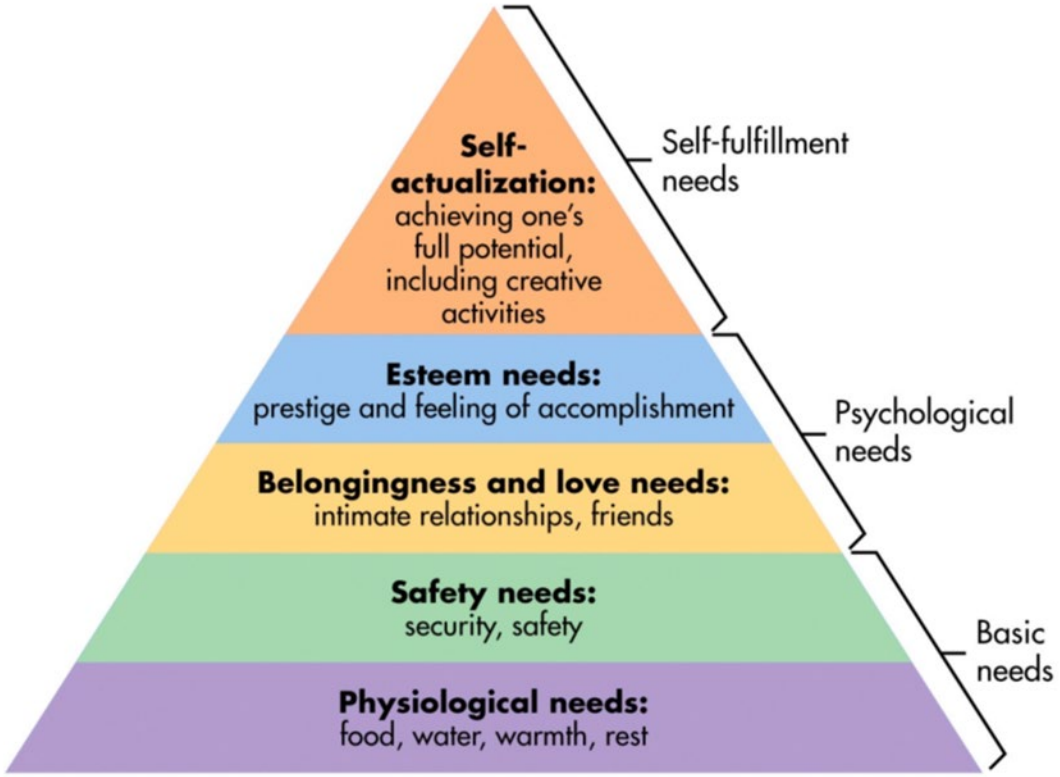
Acceptance is understanding we all wear different kinds of shoes.

Belonging is wearing the shoes you want without fear of judgment.

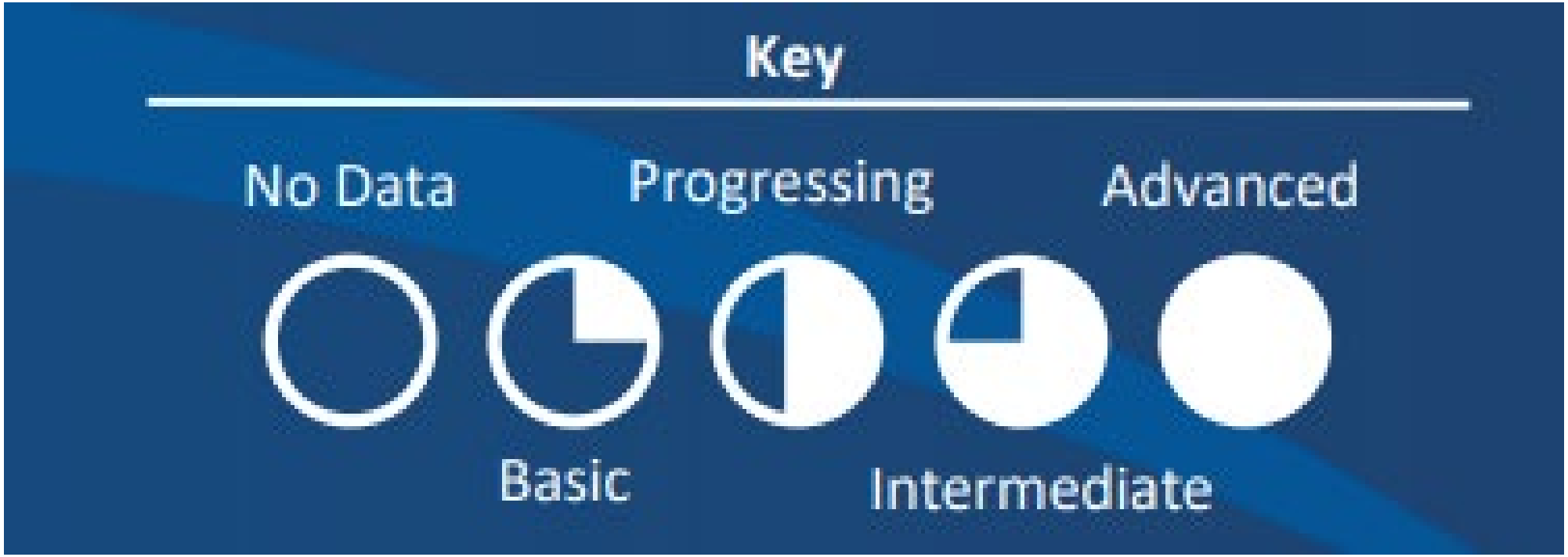
ifunny.co

Concept of Belonging

- Work that seeks to support all groups in having more equitable experiences and outcomes
- Understanding the lived experiences of communities with shared identities
- Allows for development of inclusive supports and activities that meet the needs of diverse communities
- Inclusive practices ⇒ greater sense of belonging ⇒ more equitable outcomes



Metrics



Health Equity Gap Analysis

The following checklist assesses a hospital's incorporation of health equity best practices as part of its overall operations.

EQIC
EASTERN US QUALITY IMPROVEMENT COLLABORATIVE

Hospital name: _____

Date: _____

ELEMENT	BEST PRACTICE RECOMMENDATION
ORGANIZATIONAL LEADERSHIP	
Health equity is a key strategic priority with established structures and processes in place to eliminate disparities and ensure equitable healthcare is prioritized and delivered to all patient populations.	Health equity is articulated as a key organization-wid priority (e.g., goals and objectives, strategic plan, policy, protocol, pledges, mission/vision/values, data transparency, leadership buy-in, community partnerships, diverse workforce) supported by a clea business case and plan for operationalizing health equity strategies and interventions that address mul- tiple determinants of health, decrease institutional racism and strengthen community partnerships to improve health and equity.
Hospital has designated a leader(s) or functional area (i.e., health equity committee) responsible for advancing health equity and who actively engages in strategic and action planning activities to reduce disparities.	Health equity leaders are designated and held accountable for disparities reduction with establishe roles and responsibilities to champion equity and improve quality of care. Designated leaders actively engage hospital staff, patients and families and creat linkages with community stakeholders to support health equity improvement activities.
WORKFORCE TRAINING	
Hospital workforce train- ing is provided to staff who collect self-reported race, ethnicity and language data.	Training must be provided during orientation to staff who collect demographic data. Effectiveness of training should be periodically evaluated using the self-reporting methodology to remove guess- work and ensure accurate data is collected. Training updates are recommended. At a minimum, training i provided to registration/admission staff. Training ma include role-playing scripts, didactic methods or tak place online.
Hospital workforce training is provided to clinicians involved in the care of the patient regard- ing the standardized collection of SDOH data.	Training to ensure a standardized approach to screening for and documenting social needs enables hospitals to track and aggregate data across patients, target social determinants strategies, identify popula- tion health trends and guide community partnerships. Accurate documentation of social determinants also supports Z code utilization and is key to understandin how to support patients at greatest risk and ensuring patient social support, home and community-based services are enabled to manage their conditions and improve coordination of healthcare delivery.

HQIC Hospital Quality Improvement Contractors
CENTERS FOR MEDICARE & MEDICAID SERVICES IQUALITY IMPROVEMENT & INNOVATION GROUP

This material was prepared by t contract with the Centers for M Views expressed in this materia product or entity herein does n 12SOWEQICHQIC-0051-08/1

ELEMENT	BEST PRACTICE RECOMMENDATION	IMPLEMENTATION STATUS FULLY	PARTIALLY	NONE	ACTION PLAN/ NEXT STEPS List specific activities your team will seek to accomplish to fully implement each practice recommendation
WORKFORCE TRAINING					
Hospital provides cultural competency education and training to all hospital employees and clinicians.	Implementing and monitoring a cultural competency training program helps to ensure culturally responsive clinical care and services, including within operations/ strategic planning efforts. Successful programs include a cultural assessment, multiple training methods, ongoing education and measurement and tracking.				
DATA COLLECTION AND UTILIZATION					
Hospital uses a self-re- porting methodology to collect REaL data from the patient, family member and/or care partner	State/national requirements and federal poli- cies include collecting and reporting REaL data. Self-reported patient data is preferred. All race and ethnicity categories collected should, at a minimum, roll up to the OMB categories in separate fields in addition to collecting granular ethnicity data beyond the OMB categories. Hospital staff should receive data collection training.				
Hospital has standardized processes in place to col- lect REaL data for at least 95% of its patients with an opportunity for verifica- tion at multiple points of care beyond registration.	Although most hospitals collect patient REaL data, these data are not collected in a systematic or standard manner leading to missing, incomplete or inaccurate data. Establishing data integrity checks, processes and protocols (e.g., hard stop) for self-reported REaL data collection and verification at multiple points of care beyond registration prevents missed opportunities to collect data (e.g., during pre-registration process, registration/admission process, inpatient units, prior to discharge, etc.). The timely, accurate and consistent collection of patient information allows hospitals to provide appropriate and tailored patient education, language assistance services and track quality indicators and health out- comes to improve quality and equity of care.				
Hospital uses a self-re- porting methodology to collect SDOH data (i.e., transportation, food inse- curity, housing, etc.) from the patient, family member or care partner.	Best practice recommendations include collection of SDOH/social risk factors to mitigate health disparities, which can drive as much as 80% of health outcomes. Collecting these data helps organizations identify existing disparities, address health-related social needs and connect patients with resources to address unmet needs.				
Hospital uses self- reporting methodology to collect sexual orientation and gender identity data.	Implementing SOGI data collection improves quality of care for LGBTQ+ patients and provides healthcare institutions information to identify and close quality of care gaps, improve patient satisfaction and expand patient population. Research has shown SOGI ques- tions are widely understood and accepted by diverse patient populations across the country.				
Hospital data demon- strating health equity gaps are shared broadly (i.e., use of equity dash- boards or other reporting mechanism) with key stakeholders.	Transparently sharing health equity data (i.e., REaL stratified, patient experiences, outcomes and quality data) helps to identify clinical areas where poten- tial inequities exist, analyze root causes, set aims to address gaps and target/implement interventions to close gaps and improve quality of care. Reporting: Adding REaL, SDOH and other patient demographic data to reports can inform value-based care opportu- nities to advance health equity.				

ELEMENT	BEST PRACTICE RECOMMENDATION
DATA COLLECTION AND UTILIZATION	
Hospital collects and utilizes data about the demographic and socioeconomic status of patient population(s) served and the surround- ing community (social determinants) to target interventions and address health-related needs.	Collection and utilization of needs assessments can help your program determine where and how resources may best be targeted. Collecting data by demographic and socioeconomic subgroups of patients allows hospitals to identify gaps in care delivery and other factors that may influence health outcomes to improve quality, patient safety and communication between providers and patients, care partners and families. Examples: surveys, questionnaires, focus groups and secondary data sources, i.e., demographic data, vital statistics, hospital records and M&M reports. Combining quantitative and qualitative data can help to explain community trends.
Hospital analyzes SDOH "Z code" data to improve quality, care coordination and experience of care.	SDOH health-related Z codes ranging from Z55-Z65 are the ICD-10-CM encounter reason codes used to document SDOH data (e.g., housing, food insecu- rity, transportation, etc.). Coders can assign SDOH Z codes based on self-reported data and/or information documented in an individual's healthcare record, and data analysis of SDOH Z code data can be used to identify individual's social risk factors and unmet needs, inform healthcare and services and trigger referrals to social services and between providers and social service organizations.
DATA VALIDATION	
Hospital verifies the accu- racy and completeness of patient self-reported demographic data to improve reliability and identification of disparities in care and target quality interventions (Goal >90%).	Standardized processes are in place to both evaluate the accuracy and completeness (percent of fields completed) of self-reported REaL data, including petcent of 'unknown' 'refused/declined' or 'unavail- able' with a cumulative goal of <5%. Analysis of these percentages is a valuable tool for identifying and improving issues within data collection systems and processes. Increasing the accuracy and completeness of self-reported REaL data allows hospitals to better identify disparities in patient populations and imple- ment programs to improve outcomes.
DATA STRATIFICATION	
Hospital stratifies patient safety, quality/and or outcome measures (e.g., 30-day readmission rates) by race, ethnicity and language to examine differences and equity of care provided.	Stratifying patient safety, quality and/or outcome measure(s) using patient self-reported REaL data helps to identify differences in patient outcomes, areas of opportunity and target interventions. Information can be gathered routinely at registration, updated at regular intervals and used, for example, to do predictive modeling to address factors that influence readmissions.

ELEMENT	BEST PRACTICE RECOMMENDATION	IMPLEMENTATION STATUS FULLY	PARTIALLY	NONE	ACTION PLAN/ NEXT STEPS List specific activities your team will seek to accomplish to fully implement each practice recommendation
HEALTH LITERACY, CULTURAL COMPETENCE AND LANGUAGE					
Health literacy level screened and documented within 24hrs of admission.	Patients with low health literacy are at risk for readmission. Assessing patients' ability to understand health information and responding appropriately to patients' level of health literacy is essential.	○	○	○	
Patients are screened for language access/assistance services.	Patients with limited English proficiency are at higher risk for preventable readmission than English- speaking patients. Collect data on language by asking the patient's preferred spoken language for care, as well as preferred written language.	○	○	○	
Patient cultural prefer- ences documented to individualize care/treat- ment plan.	Effective clinician-patient communication is directly linked to improved patient satisfaction, adherence and health outcomes. Best practices include docu- menting and tailoring care in alignment with patients' cultural practice and beliefs when planning, providing and evaluating care.	○	○	○	
Patient disability status/ assessment documented.	People with disabilities have more complex admis- sions. Collecting patient disability status can help ensure necessary information is gathered to provide appropriate care, interventions, services and a smooth transition after hospitalization.	○	○	○	
COMMUNITY PARTNERSHIPS					
Hospital partners with community-based orga- nizations to maximize cross-sector partnerships and meet patients' and communities' needs.	Effective, sustainable partnerships between health- care organizations and CBOs (e.g., providing direct assistance to address health-related social needs, use of Bridge Model of transitional care, use of innovative models to enhance integration processes and improve scalability) are key to addressing social needs, optimizing patient navigation strategies and improving overall health and well-being of individuals and communities served.	○	○	○	

Implementation Plan Discussion

Questions?