Closing the Chasm: The Potential Role of the Pharmacist in Addressing Disparities in Healthcare

Event Type
Live Online

ACPE Expiration Date
10/03/2016

Credits
1 Contact Hour

Target Audience
Nurses, Pharmacists, Pharmacy Technicians

Program Overview
Healthcare disparities continue to exist despite increased awareness of and attention to their existence. The causes of healthcare disparities are, for many patients and patient populations, multifaceted and highly complex. The program will focus on the healthcare disparities that exist for patients with diabetes and address how pharmacists and other pharmacy personnel can address healthcare disparities.

Nurse Educational Objectives
• Summarize existing disparities in healthcare including, but not limited to, those related to education, access, socioeconomic status, and racial and ethnic differences
• Using patients with diabetes as a case example, develop a plan for how you and other pharmacy personnel can adjust your current practice to address healthcare disparities

Pharmacist Educational Objectives
• Summarize existing disparities in healthcare including, but not limited to, those related to education, access, socioeconomic status, and racial and ethnic differences
• Theorize how pharmacists, as trusted and accessible healthcare professionals, can identify and address existing healthcare disparities
• Using patients with diabetes as a case example, develop a plan for how you and other pharmacy personnel can adjust your current practice to address healthcare disparities
Pharmacy Technician Educational Objectives

- List types of disparities seen in health care
- List types of people with diabetes who are less likely to receive proper treatment than others

Activity Type
Knowledge

Accreditation

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Faculty

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Health and Healthcare Disparities

• Misconception:
  • Results of medication therapy will be the same for all patients
  • Not all patients or populations of patients are identical to the typical clinical trial patient

Program Objectives

• Summarize existing disparities in health care including, but not limited to, those related to education, access, socioeconomic status, and racial and ethnic differences.
• Theorize how pharmacists, as trusted and accessible healthcare professionals, can identify and address existing healthcare disparities.
• Using patients with diabetes as a case example, develop a plan for how you and other pharmacy personnel can adjust your current practice to address healthcare disparities.
Health Disparities vs. Healthcare Disparities

- Health disparities
  - Differences among population groups (ethnicity, gender, income) in the incidence, prevalence and outcomes of health conditions, diseases, and related complications of diseases.
- Healthcare disparities
  - Differences among population groups in the availability, accessibility, and quality of healthcare services aimed at prevention, treatment, and management of diseases and their complications, including screening, diagnostic, treatment, management, and rehabilitation services.
- This program will touch on both.

Where are we with health disparities?

- One of the major goals of health care reform
- Little, if any, progress being made

Major Areas of Health Disparities and Inequalities in the United States

- Social determinants
  - Education and income
- Environmental hazards
  - Housing and air quality
- Healthcare access and preventive health services
  - Health insurance coverage, vaccination coverage, cancer screening

Major Areas of Health Disparities and Inequalities in the United States

- Health Outcomes
  - Mortality
    - Infant deaths, suicides, drug-induced deaths, etc.
  - Morbidity
    - Obesity, potentially preventable hospitalizations, diabetes, etc.
- Behavioral Risk Factors
  - Binge drinking, adolescent pregnancy and childbirth, cigarette smoking
Specific Areas of Disparity Relevant to Pharmacists

Influenza Vaccination Coverage

- Compared with non-Hispanic whites, among all persons ≥6 months, lower influenza vaccination coverage observed for non-Hispanic blacks and Hispanics
- Disparities in childhood vaccination coverage has improved over the past decade
- Disparities among adults ≥65 have persisted.

Drug-Induced Deaths

- In the United States in 2007, 38,371 drug-induced deaths occurred
- Prescription drugs caused more deaths than illicit drugs
- All racial/ethnic groups have observed increases in drug-induced death rates in recent years
- Highest rates overall among non-Hispanic whites

CHD and Stroke

- Black women and men have much higher CHD death rates in the 45-74 age group than men and women of other races
- 37.9% of black women died before 75 due to CHD (white = 19.4%)
- 61.5% of black men died before 75 as a result of CHD (white = 41.5%)
- Same results seen for stroke
## Obesity

- Racial/ethnic differences not changing over time
- **Prevalence lower in whites than blacks and Mexican-Americans**
- Females – highest prevalence among blacks
- Males ≤20 – highest among Mexican-Americans
- **Limited racial/ethnic differences for men ≥40**
- Overall, differences exist after controlling for differences in income
  - White women with higher income = less obesity
  - White males (2-19) with higher family income = less obesity
  - Black men with higher income = more obesity

## Preventable Hospitalizations

- Rate higher among non-Hispanic blacks and Hispanics than non-Hispanic whites
- Rate lower among Asian/Pacific Islanders than non-Hispanic whites
- Higher among those in lower income quartiles

### CDC comments:
- Eliminating income-related disparities – prevents 1 million hospitalizations and saves $6.7 billion/year
- Redesign of primary care delivery and chronic disease management needed
- Improving care coordination and reducing barriers to care for specific groups – proven effective

## Current Asthma

- Approximately 7.8% of the US population has asthma
- Prevalence higher among multi-racial, Puerto Rican Hispanics, and non-Hispanic blacks than among non-Hispanic whites
- Prevalence higher among children than adults
- Prevalence higher among females than males
- **Prevalence higher among the poor than non-poor**

## Adolescent Pregnancy and Childbirth

- US birth rates for adolescents vary considerably by race
- Rate for Hispanic adolescents:
  - 5x the rate for Asian/Pacific Islander adolescents
  - 3x the rate for non-Hispanic white adolescents
  - Somewhat higher than rates for non-Hispanic black and American Indian/Alaska Native adolescents
### Cigarette Smoking
- From 1965-2008, smoking among male and female adult smokers ≥18 has declined for non-Hispanic white and non-Hispanic black.
- Higher smoking prevalence for American Indian/Alaska Native.
- Those at or near federal poverty level – higher prevalence.
- Rates decreased with increasing education.
- Unemployed had higher rates.

### Diabetes
- Overall prevalence of diabetes continues to increase.
- Increasing faster among racial/ethnic minorities.
- Blacks and Hispanics have statistically higher rates than whites in men and women.
  - Racial/ethnic disparities remaining constant over time.
- Greatest disparities existed in those with lowest level of education and those living below federal poverty level, or both.
  - Socioeconomic disparities worsening over time.
- Disparities also exist based on age, disability, and US census region (South).

### Diabetes Complications
- Rates are higher in certain racial/ethnic groups.
  - Diabetic retinopathy – 84% higher in Mexican-Americans than non-Hispanic whites.
  - Renal insufficiency – 3-6x higher.
  - ESRD – 41% higher.
  - Lower extremity amputation – 2x more common.

### Examples of Success
- Interventions targeted at disparities have improved each of the following areas:
  - Regular physical activity.
  - Patient diet.
  - Adherence.
  - Mean glucose values.
  - HbA1c.
How Can Pharmacists Address Healthcare Disparities in Patients with Diabetes?

1. Recognize the Problem

Existence of Medical Culture

- Similar to political beliefs and/or religious beliefs, there are medical beliefs
- Different people recognize the following differently:
  - The ways a person is recognized to be ill
    - Identification of clinical changes
    - Perceiving these changes as being significant
  - The ways a person presents illness to others
  - The way illness is addressed
    - Deciding to treat or not to treat
    - Choosing sources of treatment
    - Acting on the choice of treatment

Application of Medical Culture to Diabetes

- Symptoms may not be apparent
- Physical changes may not be apparent
- Severity of the problem may not be uniform
- Discussion of health problems may be discouraged
- What you consider treatment, your patient may not consider treatment
- While your focus is likely to be prescription drugs, your patient’s focus may be elsewhere
How Can Pharmacists Address Healthcare Disparities in Patients with Diabetes?

1. Recognize the Problem

2. Gain Cultural Competence

Misconceptions

- First, must address beliefs and misconceptions
  - Patients who don’t practice health behaviors don’t care about their health.
  - Traditional beliefs should be changed rather than built upon.
  - Adherence failure is all the patient’s problem.
  - Everyone understands the concept of “chronic illness.”
  - Healthcare is available and accessible to all.

Specific Examples of Belief Differences

- Some Asian cultures believe that discussing a potential health problem increases its likelihood.
- Many cultures believe that a heavier physique is indicative of health.
- Some Chinese believe extra weight is a blessing related to wealth and prosperity.
- Many cultures believe that diabetes is brought on by sweets, stress and worry, or a punishment for immoral behavior.
- Some Native American tribes believe that diabetes was introduced by the “white man”.
- Native American categorize illness by pain, disability, and discomfort.
- Chinese-Americans may consider diabetes a “hot” or yang disease.
- Fasting may be highly significant.
- Often, reluctance to try new foods.
Results of Belief Differences

- Lack of recognition of the problem
- Lack of desire to communicate
- Different communication styles
- Reliance on herbal remedies
- Reliance on prayer and meditation
- Resistance to behavior change
- Guilt and shame
- Blame

How Can Pharmacists Address Healthcare Disparities in Patients with Diabetes?

1. Recognize the Problem
2. Gain Cultural Competence
3. Focus on Adherence

Adherence

- Adherence rates for diabetes medication are poor.
- Racial/ethnic disparity in adherence exists
  - Long-term and short-term differences in adherence exist
    - Studies have shown that African-American patients are more likely to discontinue oral diabetes medications
    - In one study, patients were followed for 24 months
      - Equal access to medication ensured
      - >50% of African-Americans discontinued therapy
      - 44% of whites discontinued therapy

Focus on methods to increase adherence in all populations.

How might adherence interventions be targeted to certain populations?
How Can Pharmacists Address Healthcare Disparities in Patients with Diabetes?

1. Recognize the Problem
2. Gain Cultural Competence
3. Focus on Adherence
4. Provide Good Patient Education

What is Bad Patient Education?

- Too much detail regarding pathophysiology and mechanism and too little related to daily management
- Goals are not clearly articulated
- Recommendations are unrelated to patients’ cultural and economic situation
- Information represented in ways that are difficult for learners with low literacy to understand and implement

What is Good Patient Education?

- Assess patient beliefs
- Assess patient current practices
  - Common foods, methods of preparation, etc.
  - Lifestyle preferences and practices
- Assess learning styles
- Use community members/focus groups to test

Practical Example of Patient Education

- Oral vs. written
- Stories
- Peer Educators
- Experiential learning
- Single-concept approach
- Use of illustrations
- Use of translators
Patient Cases

- JZ is a 45 year old Hmong female who has recently been diagnosed with Type 2 diabetes.
  - Are there any health beliefs associated with JZ’s culture that may affect her treatment?

- DW is a 58 year old African-American male who has been sent to you for diabetes education. DW states that he has a case of “sweet blood”.
  - What implications may this have for DW’s diabetes treatment plan?

- GL is a 40 year-old Native-American male who has been diagnosed with Type 2 diabetes. He has been prescribed:
  - Metformin 500 mg po bid
  - Are there any factors of which you need to be aware when you emphasize the importance of adherence to GL?

Questions?