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CSHP mission

To Represent and Empower Pharmacists and Pharmacy Technicians Practicing in Health-Systems to Promote Wellness, Patient Safety and Optimal Use of Medications

CSHP vision

Pharmacists are Recognized as Leaders in Wellness, Patient Safety and the Optimal Use of Medications

Peer Review

The California Journal of Health-System Pharmacy is a peer-reviewed publication!

The CSHP Editorial Advisory Board is pleased to announce that the *California Journal of Health-System Pharmacy* has completed the transition to peer review.

Peer reviewed, or refereed, publications utilize an editorial process to ensure that the articles published are as scholarly as possible. From this point forward, when an article is submitted to *CJHP*, the editors will send it out to other (peer) pharmacists and clinicians in the same field to obtain their opinion as to the appropriateness of the manuscript for publication, the relevance to the field of study, and the quality of the research.

Instructions for Authors

The *California Journal of Health-System Pharmacy* welcomes article submissions in any field pertinent to the practice of health-system pharmacy. All manuscripts submitted are subject to peer review. To submit a manuscript for publication, please visit http://cshpjournal.msubmit.net. Authors without access to the internet may send a printed copy of their manuscript along with a CD, DVD or USB drive to: CJHP, attn: Managing Editor, 1314 H Street, Suite 200, Sacramento, CA 95814.

For more information on article submission, Peer Review, or *CJHP*, please contact Cindy Hespe, Managing Editor, *CJHP* at chespe@cshp.org or 916.447.1033.

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Cover image: prism

President's Perspective

Kethen So, PharmD, FCSHP
CSHP President

I hope all is well for everyone! It is the time of year when many graduations happen. People travel all over the country to celebrate the achievements of their loved ones. Many graduating student pharmacists are also busy preparing for their CPJE and NAPLEX exams. I want to wish all students success in the final step of their pharmacy education journey before they enter the workforce to care for the public.

This is also the time of the year that CSHP calls for volunteers to serve on the next year's Committees, Councils, and Task Forces (CCTFs). We received a huge number of submissions from our members willing to volunteer, and President-elect Vicky Ferraresi will soon begin to appoint the CCTFs for next year. I can't stress enough that volunteers are the lifeblood of CSHP. With a total of fifteen different CCTFs, there are many charges and new initiatives that the Society has committed to in promoting the profession. Working with our dedicated CSHP staff, volunteers are critical to our success. In my year as CSHP president, I appointed over 170 volunteers to serve on the CCTFs. Have you ever wondered why people volunteer? Of course, there are many different reasons. Commonly, people find that volunteering is a way to give back to the community. CSHP members see volunteering as an opportunity to give back to the profession and to educate the public about the role of pharmacists. Regardless of the reason, the passion and energy gathered by a group of dedicated volunteers are powerful. Nothing seems to be impossible. One success story from our Society is how the many volunteer members worked tirelessly together to educate legislators about SB 493 at both the local and state level. Without the volunteers' efforts, California pharmacists would not have the privilege of being recognized as healthcare providers today. I know that there are many competing priorities in life, work, and family. I want to share with you a quote by Elizabeth Andrew, "Volunteers do not necessarily have the time; they just have the heart." Please consider volunteering next time someone offers you the opportunity.

After multiple months of preparation as the contract organizer, CSHP delivered another successful annual Western States Conference at Paradise Point, San Diego in May. A record number of residents and preceptors attended the conference. CSHP also reviewed and granted ACPE continuing pharmacy education credit for over 600 presentations. The effort by the CSHP staff who make this happen is greatly appreciated. I hope many of you also attended the conference to witness the success and provided constructive feedback to our future leader residents.

In June, ASHP held their 2016 Annual Meeting in Baltimore, MD, which included their House of Delegates, the body that develops ASHP professional policies. I was fortunate to serve as the leader of the California delegation. The California delegates included Victoria Serrano Adams, Christine Antczak, Vicky Ferraresi, Steven Gray, Brian Kawahara, Bill Yee, Scott Takahashi, and myself. The delegate responsibilities began by reviewing the many proposed policies at the Regional Delegates Conference in April. At the House of Delegates, multiple controversial policies were presented. Our California delegates shared their cutting-edge, practice-related experiences with delegates from across the country. Direct-to-consumer advertising, cultural competency and cultural diversity, and controlled substance dispensing were among the most highly debated topics. Many thanks to the great work by our California delegates!

As the saying goes, "Time flies when you are having fun." I have reached the midpoint of my presidency, and I have enjoyed every moment of it. In every conversation with both CSHP members or non-members, I always learn something new about the challenges and successes of our profession. CSHP is going through a "rebuild" year and is blessed with a group of new and seasoned staff to support our members. I remain very confident that CSHP has the unique position to continue promoting and advancing the pharmacy profession.

Take care! ○

The Role of Health-System Pharmacy in Addressing Health Equity and Healthcare Disparities

Rowena Bartolome, RN, BSN, PHN, MHA • Abir Makarem, PharmD
Annet Arakelian, PharmD, FCSHP, CPHQ

Learning Objectives:

After reading this article, the reader should be able to:

1. Define key terms associated with health equity and provisions of equitable care
2. Discuss the national efforts to address health disparities
3. Identify recommended strategies that can be used by a pharmacy health system to narrow the healthcare disparity gap
4. Demonstrate how to advance health equity goals within pharmacy practice across the continuum of care
5. Implement interventions to improve pharmacists' awareness of health disparities and patient outcomes
6. Explain how to access and use resources for addressing health disparities.

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Introduction

Since 2001, when the "Crossing the Quality Chasm" report was first published by the Institute of Medicine (IOM), healthcare organizations, professional groups, as well as private and public purchasers in the United States have implemented sweeping changes to restructure healthcare systems. The report recommends the provision of equitable care in addition to safe, effective, patient-centered, timely, and efficient care. Equitable care is "providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status."[1] Furthermore, the IOM report, "Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare" published in 2002 concluded that "although myriad sources contribute to these disparities, some evidence suggests that bias, prejudice, and stereotyping on the part of health care providers may contribute to differences in care."[2]

More recently, according to the 2015 National Healthcare Quality and Disparities Report and 5th Anniversary Update on the National Quality Strategy, the quality of healthcare improved generally but healthcare disparities persist especially among people in poor households, Hispanics/Latinos (Hispanics), and Blacks/African Americans (blacks).[3]

Role of Health-System Pharmacists and Pharmacy Technicians in addressing Health Equity and Healthcare Disparities

Significant disparities exist in medication treatment received by racial and ethnic minorities and women.[4] Pharmacists and pharmacy technicians working in health systems have an important role in the provision of equitable care and toward addressing disparities in their respective practice settings. The American Society of Health-Systems Pharmacists (ASHP) published a comprehensive guideline in their Statement on Racial and Ethnic Disparities in Health Care.[5] The statement outlines 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 healthcare

Seven recommended strategies that can be used as a checklist for a pharmacy health-system in closing the healthcare disparity gap are listed in Table 1.

Raising awareness that reducing health disparities needs to be a focus on quality improvement is an important early step. Pharmacists and pharmacy technicians have a vital role in increasing the level of awareness among other healthcare providers, administrators, legislators, regulators, payers, and the public. This can be best accomplished by analyzing institutional data and by highlighting outcomes for various populations and risk groups, by race, ethnicity, gender, etc. For example, at Baylor Health Care System, the organization assessed two focus areas: 1) delivery of adult clinical preventive services by patient age, sex, and socioeconomic status and, 2) delivery of The Joint Commission (TJC) core measures by quality of in-hospital care by race/ethnicity, sex, and age.[6] This process revealed areas of opportunity to address age-related disparities for adults, age 65 and older, who were more likely to have had blood pressure, cholesterol, colorectal, and breast cancer screenings compared to younger patients. For TJC core measures, it was noted that, compared to whites, Hispanics were significantly less likely to receive aspirin at discharge for prevention and blacks were significantly less likely to receive percutaneous transluminal coronary angioplasty within 90 minutes of hospitalization for acute myocardial infarction (AMI). A health system can leverage similar analytics to implement quality improvement strategies in areas with identified healthcare disparities and then measure progress towards closing these gaps.

Several quality improvement strategies are recommended by ASHP. One is creating a more diverse work force which promotes increased racial concordance between the patient population served and the healthcare provider staff, a characteristic that is positively associated with better health outcomes.[7] This involves hiring employees from vulnerable, underserved populations such as the Limited English Proficient (LEP) populations. To help build capacity, hiring and developing students and interns from underserved groups for future employment opportunities in the pharmacy profession are viable strategies. Healthcare organizations can engage with pharmacy and pharmacy technician schools to provide experiential and introductory and advanced experiential opportunities at practice sites. In the absence of programs targeting underserved groups in pharmacy, launching a program specific to pharmacy in the general population provides opportunities eventually promotes workforce diversity.

In addition to building a diverse healthcare workforce, developing cultural competencies in healthcare, related to, e.g., ethnicity, age, gender, race, sexual orientation, cultural beliefs, is equally important to address the needs of a diverse population. Understanding the diversity in those communities served by the health system provides a context that can be used to develop cultural competency programs for its workforce.

Since the passage of the Affordable Care Act, Accountable Care Organizations can develop care delivery models that ensure that multidisciplinary teams leverage the strengths of each caregiver by allowing them to practice at the top of their license according to their legal scope of practice. Pharmacists who function as advanced practice clinicians and are also members of a high-functioning healthcare team contribute to improved clinical outcomes and reduced workload for primary care physicians.[8] Pharmacists are uniquely trained to address medication management and polypharmacy issues and have contributed to improved patient safety, quality and affordability outcomes by participating in integrated healthcare teams, which have demonstrated to improve health outcomes.[9]

There is a paucity of direct research on the role of pharmacists in addressing healthcare disparities through optimized medication management, communication strategies, and patient-centered interventions. Youmans, et al. conducted a focus group study with older blacks living in community centers and showed that the role of the pharmacist is not fully realized among this population of insured, older black Americans with chronic disease. They concluded that further research is needed to examine the patient-pharmacist relationship and its role in contributing to healthcare disparities.[10] Additional work is needed in this area to develop pharmacy practice further in providing equitable care.

Furthermore, pharmacists who manage population health have a role in addressing social determinants of health and, through research and evaluation, can demonstrate the impact

Table 1. Strategies to Close the Healthcare Disparity Gap

1.	Collection of self-reported REAL (Race, Ethnicity and Language), gender, age, etc., and monitoring of data on health disparities
2.	Promoting awareness of the existence of health and healthcare disparities
3.	Providing culturally competent care and services
4.	Communicating effectively to build trust and improve connections between patients and healthcare providers
5.	Building a more diverse healthcare work force
6.	Creation of multidisciplinary teams and evidence-based guidelines,
7.	Conducting research activities to evaluate strategies to address disparities in healthcare

of pharmacy-specific interventions on public health. Multiple determinants of health such as social, behavioral and environmental factors can account for up to 60% of the factors driving health outcomes, whereas, clinical factors contribute no more than 10%.[11] Dr. Georges Benjamin, the executive director of the American Public Health Association, calls upon pharmacists to play a key role in the transformation of the healthcare system by using principles of population health to address unmet healthcare needs.[12] A good example is an asthma surveillance program where a pharmacy manager tracked unusual prescription patterns and contacted the local health department to investigate and identify an environmental source contributing to the asthma morbidity for multiple children. In that program, the environmental source was a broken tail pipe of the school bus being used by the community. Dr. Benjamin advocates for pharmacists to partner with other disciplines to perform population health surveillance and risk reduction strategies.

Improving Medication Adherence among Racially and Ethnically Diverse Populations

Non-adherence to medication dosing instructions contributes to suboptimal health outcomes and increased healthcare costs and mortality. Medication adherence rates among patients with chronic conditions are estimated to be between 50% and 60%.[13-15]

Medication non-adherence can be influenced by a myriad of factors including patients' race and ethnicity. The World Health Organization (WHO) listed five factors that affect people's behavior and capacity to adhere to taking their medication as prescribed. The five factors identified included: health system/healthcare team, socioeconomic status, factors related to the prescribed therapy, condition-related factors, and patient-related factors.[15]

Several studies have measured adherence to medication instructions among patients with different races and ethnicities and pointed to a disparity among minority groups.

In a Kaiser Permanente (KP) Northern California study, Traylor, et al. assessed adherence to cardiovascular (CV) medication instructions among different racial groups, and found that, compared to white patients, black, Hispanic and Asian patients were significantly less likely to have good adherence to all of their CV risk factor controlling medication instructions.[16]

In a study by Zhang, et al., medication adherence among minority Medicare Part D beneficiaries was evaluated. The study compared medication adherence among Medicare patients with heart failure by disability status, race/ethnicity, and income. The study found that minority beneficiaries, including Native Americans, blacks, and Hispanics were less likely to adhere relative to whites. In all adherence outcomes, racial disparity in medication adherence persisted even among patients with close to full drug benefit coverage.[17]

Lauffenburger examined gender, racial, and ethnic (white, black, Hispanic, Asian, and other) differences in the use of evidence-based preventive therapies in the 30 days after discharge and medication adherence at 12 months after discharge. The analysis reported that, compared to the white population, minorities were no less likely to initiate therapies after AMI discharge. However, black and Hispanic patients had significantly lower adherence over a period of 12 months.[18]

As evidenced by the WHO report, as well as other studies, adherence to prescribed therapies is influenced by multiple factors. Approaches to address and improve non-adherence need to be multifactorial and multidisciplinary.[15, 19]

Case Study Part 1: Addressing Health Equity and Health Disparities in an Integrated Healthcare Delivery System

Founded in 1945, KP is one of the nation's largest not-for-profit, integrated healthcare delivery systems, caring for 10.6 million members in eight states and the District of Columbia. Care for members and patients is focused on their total health and guided by personal physicians, specialists, and a team of caregivers.[20] The organization has long focused on the use of evidence-based guidelines and performance metrics to implement models of care to improve healthcare quality, service, and access. Since 2003, the KP Institute for Culturally Competent Care (CCC), sponsored by the KP National Diversity and Inclusion Department, has provided extensive tools, resources and comprehensive education to clinicians and staff on the provision of CCC while developing strategies to collect self-reported Race, Ethnicity and Language Preference (RELP) data from KP health plan members.

With the implementation of enterprise-wide Electronic Health Records (EHR)—KP HealthConnect®—the organization has generated reports from extensive databases and population registries and analyzed the data for healthcare disparities. From this information, National and Regional Equitable Care reports with 16 Healthcare Effectiveness Data and Information Set (HEDIS) measures have been published. They revealed that healthcare disparities exist among racial and ethnic populations even though all members have equal access to care. In spite of the organization's strong performance on quality outcomes and robust CCC programs, some populations

still are not receiving optimal care and are being "left behind." For example, the results for the use of HEDIS Controlling High Blood Pressure measure—the percentage of adults aged 18 to 85 years with a diagnosis of hypertension whose blood pressure (BP) was adequately controlled (< 140/90 mmHg) during the measurement year—were as follows. For the baseline measurement period ending December 31, 2009, the rate for white members was 78.4% (n = 487,421), and the rate for black members was 70.3% (n = 147,425); the difference in rates was 8.1 percentage points.[21] This data presents a significant healthcare issue: compared with whites, blacks receive a diagnosis of high BP earlier in life and their average BP levels are higher. As a result, black Americans have a "1.3-times greater rate of nonfatal stroke, a 1.8-times greater rate of fatal stroke, a 1.5-times greater rate of death attributable to heart disease, and a 4.2-times greater rate of end-stage kidney disease."[22]

Program leaders for the KP National Health Plan and Hospital Quality, Equitable Care and Health Equity began addressing disparities by building on the organization's strengths in population health management, team-based care, data management, and CCC.[23] Cultural tailoring, the "development of intervention strategies, messages and materials to conform to specific cultural characteristics"[24] for clinician and provider communication, health promotion programs and medication management strategies, was a major component in building trust and developing connections with patients. With the spread of best practices, over time, the improvement in the white-black disparity in hypertension control rates was statistically significant when measured in both December and March 2009. It decreased by 50%, from 8.1 to 3.9 percentage points. Also, colorectal cancer screening for the Hispanic/Latino population has improved, and a white-Hispanic disparity gap has also decreased.

Today, equitable care is a major component of the organization's quality strategy and the team is working toward supporting the organization's goal to focus on "Total Health" by building on past learning and expanding current activities to include health equity defined as the "attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and healthcare disparities."[25]

Case Study Part 2: Addressing Non-adherence in the Outpatient Pharmacy Setting

Because of their specialized knowledge of medications and their access to patients, outpatient pharmacists are well positioned to engage with patients to overcome many barriers to adherence.

Outpatient pharmacists at KP Southern California outpatient pharmacy address non-adherence to chronic medications by using a B-SMART consultation methodology (Table 2). Through the B-SMART consult, pharmacists identify "Barriers to medication adherence, work on Solutions to identified barriers, Motivate patients, recommend Adherence tools, Reinforce the pharmacist-patient relationship, and Triage if needed, to other services such as health education, to improve outcomes."[19]

Using the B-SMART methodology, Outpatient Pharmacy Clinical Services (OPCS) pharmacists documented patient-reported barriers to taking the medications as prescribed. The top four adherence barriers reported among OPCS patients included forgetfulness (47%), denial of condition (19%), lack of knowledge (18%), and side effects (12%).[26] Other patient-reported barriers accounted for < 4% of total reported barriers and included language barriers, cultural and religious beliefs, poor health literacy, financial barriers, and lack of social support.

By engaging non-adherent patients to restart their diabetes or lipid medications during a face-to-face consult, pharmacists using the B-SMART consult, were able to influence and improve medication adherence and clinical outcomes, particularly among patients with diabetes.[26]

To address racial disparity in medication adherence, a pharmacy pilot program collaborated with the KP Equitable Care and Health Equity national leaders

Table 2. B-SMART Methodology for Improving Mediation Adherence and Clinical Outcomes

Barriers	Identifying barriers and assessing readiness to change
Solutions	Providing patient-centered, targeted solutions to adherence challenges
Motivation	Helping patients help themselves - goal setting
Adherence Tools	Providing tools, including pill boxes, reminder calls, kp.org refill reminders, etc.
Relationships/Roles	Establishing a positive patient-provider relationship
Triage	Directing patients to other resources in the system for support, education and monitoring

to build upon the existing B-SMART consults provided in the outpatient pharmacy setting and augmented that consultation process with a culturally-tailored variation of the B-SMART consultation. This pilot program was conducted as part of an ASHP-accredited residency program and was Institution Review Board approved.

The culturally tailored version of the B-SMART methodology intended to promote basic awareness of Black American and Hispanic cultures, improve communication and build trust among pharmacists and patients (Table 3). The training was coordinated with the KP National Equitable Care and Health Equity Program leaders and was based on the Four Habits and the AIDET® communication models.[29,30]

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, and investing in the end. The AIDET® communication model includes five steps in a communication framework (Acknowledge, Introduce, Duration, Explanation, and Thank you). The five steps help to decrease patient anxiety, to build trust and increase adherence, resulting in improved health outcomes and increased patient satisfaction.[27,28]

The training, provided communication guides, techniques, and examples of the ways in which culture and health beliefs of blacks and Hispanics can be integrated into the B-SMART consultation at the outpatient pharmacy setting. Also, pharmacists were provided with a recommended consultation script to use a reference.

Pharmacy technicians, as well as all pharmacy staff members, may also incorporate the elements of the Four Habits and the AIDET communication models into patient communications to address cultural preferences, further build trust, and improve patient satisfaction.

Table 3. Culturally-tailored B-SMART Methodology to Promote Black American and Hispanic Cultures

Culturally-tailored B-SMART for Black Members	Culturally-tailored B-SMART for Hispanic Members
✓ Building trust is important for every encounter	✓ Build connections through acceptance of the individual and the culture
✓ Address the patient with formal titles (e.g., Mr., Mrs.) to convey respect for the patient and any family members brought to the consultation	✓ Introduce yourself as a pharmacist. Hispanic patients hold the physician and other healthcare providers with high esteem
✓ Avoid appearing rushed which may be viewed as discriminatory	✓ Include immediate or extended family members in consultation, if patient allows. Family members play an important part in supporting the patient's medication adherence
✓ Do not use "try this medication" due to cultural fears related to experimentation	✓ Assess language preference and utilize certified interpreters, not family members
✓ Include family members in consultation, if patient allows: family members play an important part in supporting the patient's medication adherence	✓ Include family members in consultation, if patient allows: family members play an important part in supporting the patient's medication adherence
✓ Assess language preference and utilize certified interpreters, not family members	✓ Encourage questions. About one-third of Hispanic patients leave their appointments with unanswered questions

The pilot was conducted at the KP West Los Angeles Medical Center, designated a Center of Excellence for blacks. Pharmacists provided consults to patients who were non-adherent to their oral diabetes or hyperlipidemia medications. Non-adherence was defined by medication possession ratio (MPR) of < 0.80 for medications one year prior to the consultation date, indicating lower adherence to the prescribed therapy. Preliminary outcomes to evaluate the impact of the culturally-enhanced B-SMART consult on medication adherence and related clinical outcomes show a promising positive trend. Outcomes are being finalized for future publications.

Regulatory and Policy Influence in Addressing Disparities

Beginning with the Civil Rights Act of 1964, various policies continue to drive closing the gap on healthcare disparities. This includes Race and Ethnic Standards for Federal Statistics and Administrative Act (1977) leading to the collection of data for four races (Asian or Pacific Islander, Black, and White) and two ethnic groups (Hispanic and non-Hispanic) to the Food and Drug Administration and the National Institute of Health in the mid-1990s monitoring and supporting the enrollment of women in clinical trials. In 2006, TJC set forth requirement related to the provision of culturally and linguistically appropriate healthcare. Additional policy and regulations are being developed in this area worldwide as an outcome of the WHO establishing the Commission on Social Determinants of Health in 2005. The Commission published recommendations, based on evidence, about what could be done to further the cause of health equity.

A patient's understanding of directions on how to take a medication and read a prescription label is essential in understanding how to take medication properly. The California Board of Pharmacy requires pharmacists to provide free interpreting services for LEP and non-English speakers, upon request at the pharmacy counter. In January 2016, new California requirements for prescription labels took effect that establishes a mechanism by which patients with limited English skills may obtain translated directions on their prescription container labels or as a supplement to the label. This law was authored by Assembly Member Ting as AB 1073, and amends Business and Professions Code sections 4076 and 4199 and creates new section 4076.6.

AB1073 requires pharmacies to provide their own translations of prescription instructions into Chinese, Korean, Russian, Spanish, and Vietnamese when requested by patients or their caregivers. If they cannot provide their own translations, they must use the state Board of Pharmacy's 15 standardized directions when appropriate to the prescriber's directions for use.

The law recognizes that many dispensers already provide translations on prescription containers. The enacted legislation allows this practice to continue. (http://www.pharmacy.ca.gov/publications/translations.shtml)

Summary

Healthcare organizations and health systems currently have a golden opportunity to improve quality and patient-centered care when viewed through the health equity lens. With the consistent collection of data on self-reported RELP that is now available in EHRs, quality programs, performance improvement projects and implementation strategies can be evaluated for the presence of healthcare disparities. Pharmacists who function in high performing healthcare teams as advanced practice clinicians make an important contribution to population health strategies through medication management and culturally tailored interventions, promoting trust and building connections with racial and ethnic populations. Since the adoption of the Civil Rights Act in 1964, and with the implementation of the Affordable Care Act, regulatory bodies continue to focus on the need to address heath equity and healthcare disparities. More importantly, understanding patients through the health equity lens will help clinicians to truly provide "patient-centered care." Pharmacists and pharmacy technicians are uniquely positioned to provide such care and to advocate for this change. ○

Resources with Extensive Material and Resources to Support Healthcare Equity Efforts

Resources	Web Address	Comments
Agency for Healthcare Research and Quality	www.ahrq.gov	Includes tools ranging from training programs for low health literacy, cultural competency, and research on diversity, equitable care
Think Cultural Health	www.thinkculturalhealth.hhs.gov	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)
National Center for Health Statistics	www.cdc.gov/nchs	State and federal database with health and delivery statistics including ethnicity, age, gender, and others
American Association of Colleges of Pharmacy	www.aacp.org	Curricular resource center has materials for underserved populations, including cultural competence resources
Institute for Healthcare Improvement	www.ihi.org	Clearinghouse of resources, white papers, etc. in working towards meeting the six aims of quality, including equitable

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Laura Cranston

Pharmacy Quality Alliance and Healthcare Reform

An Interview with PQA Executive Director Laura Cranston, RPh

Interviewed & written by Pauline Chan, RPh, MBA and Jackie Ho, PharmD, MPH

In April 2016, the CSHP Committee on Healthcare Reform (HRC) invited Pharmacy Quality Alliance (PQA) Executive Director Laura Cranston, RPh, for an interview. As PQA's founding executive director, Laura oversees the development of medication use measures and works with many organizations including health plans, pharmacy benefits management services, community pharmacy organizations, employers and others to promote the integration of meaningful medication use measures in the marketplace. Additionally, Ms. Cranston represents the pharmacy profession in the National Priorities Partnership (NPP), convened in 2010 by the National Quality Forum (NQF). The NPP, made up of fifty-two major national organizations, shares with NQF a vision to achieve better health, and a safe, equitable, and value-driven healthcare system.

In this interview, Ms. Cranston shares with HRC members Pauline Chan and Jackie Ho and CSHP President-elect Vicky Ferraresi how PQA has evolved into a national leader in medication use measure development. Ms. Cranston has made significant contributions in advancing the pharmacy profession through pharmacist education and training in the use of quality measures to improve patient care. Under her leadership, PQA created EQuIPP (Electronic Quality Improvement Platform for Plans & Pharmacists), an electronic quality improvement platform designed primarily for health plans and pharmacies. PQA also developed an educational program called EPIC (Educating Pharmacists In Quality), a program suitable for course curricula in pharmacy schools and postgraduate programs. As electronic health records (EHRs) are becoming the norm, PQA is also developing an e-clinical measures platform to meet future demands.

CSHP Committee on Healthcare Reform

Healthcare is a constantly evolving landscape. The CSHP Committee on Healthcare Reform was formed to help chart a path to a future where pharmacists are integrated into every part of the care continuum.

Responsibilities of the CSHP Committee on Healthcare Reform include:

1. Update and distribute a catalog of available resources to the public
2. Educate members about healthcare reform
3. Publish demonstrated value of the pharmacists' role in care delivery
4. Administer Innovative Pharmacy Practice Award (IPPA) including, but not limited to, developing application materials, reviewing applications, selecting and notifying awardees/honorees with oversight from the CSHP Board of Directors.

CSHP's Committee on Healthcare Reform consists of a diversified group of pharmacy practitioners, including pharmacists, new practitioners, residents, pharmacy technicians, and student pharmacists as well as CSHP staff.

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Acting Chair	Pauline Chan	Sacramento Valley
Immediate Past Chair	Helen Park	Quatra County
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	Michael Moore	Golden Empire
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Resident PGY2	Jackie Ho	Quatra
Technician	Ava Hacopian	Southern California
Student Pharmacist	Vanessa Ma	University of Southern California
Board Liaison	Annet Arakelian	Southern California
Ex-Officio	Loriann DeMartini	CSHP CEO
Committee Manager	Dianne Coker	CSHP

Acronym	Definition
DHHS	Department of Health and Human Services
DTP	Drug Therapy Problem
eCQMs	e-Clinical Quality Metrics
EHR	Electronic Health Records
EPIC	Educating Pharmacists in Quality
EQuIPP	Electronic Quality Improvement Platform for Plans & Pharmacists
IEHP	Inland Empire Health Plan
MAP	Measure Applications Partnership
MTM	Medication Therapy Management
NPP	National Priorities Partnership
NQF	National Quality Forum
PQA	Pharmacy Quality Alliance
PQS	Pharmacy Quality Solutions

Thank you for visiting us, Ms. Cranston. Can you first tell us what are the mission and goals of the PQA?

Laura: PQA's mission and goals are to develop and implement metrics for assessing appropriate and safe medication use and to implement best practices across our membership to improve patient care.

Pauline: How would you describe PQA's journey from its inception in 2006 through its current role?

Laura: When PQA started in 2006, our primary role was to develop medication use measures for the Medicare Part D program. Since that time, our metrics are used increasingly by non-Medicare programs. These programs include the health exchange marketplace, state-based health alliances and employer coalitions. Regional health plans, such as the Inland Empire Health Plan (IEHP) in Southern California, have also incorporated and adopted our metrics into their performance-based models.

There is now a tremendous movement to adopt Core Measure sets. So instead of the marketplace introducing or implementing a single metric here or there, the move is to have Core Measure sets. For example, there is a Core Measure set for adult Medicaid beneficiaries and a Core Measure set for child Medicaid beneficiaries. A key milestone for PQA is that some of our measures have been accepted into these new Core Measure sets.

Pauline: This is very exciting. Can you elaborate on how PQA incorporates their measures into the Core Measure set?

Laura: Essentially there is a group of stakeholders called the Measure Applications Partnership (MAP) in Washington D.C. Formed in 2011 under a provision of the Affordable Care Act, this group is comprised of health system providers, doctors, pharmacists and other measure developers. The MAP makes recommendations to the Department of Health and Human Services (DHHS) on what measures should be incorporated into the Core Measure set. During the annual meeting, the MAP presents DHHS with a List of Measures under Consideration, typically numbering 700 or more, which might be used in any one of the 24 federal payer programs (e.g., hospital, nursing home, or Medicare Part D programs).

The MAP applies Measure Selection Criteria to all the proposed measures to create the final Measures under Consideration List, asking themselves is this a "me too" measure or is this something new and different? Does it have an advantage over something that is already in use?

Pauline: I understand that the MAP review process is very rigorous. Congratulations on this tremendous recognition! PQA has come a long way since its inception. Can you talk more about how you work with specific plans, such as IEHP, to incorporate these measures?

Laura: The IEHP uses a platform that was initially created by PQA and is now operated jointly as Pharmacy Quality Solutions (PQS). EQuIPP (Electronic Quality Improvement Platform for Plans & Pharmacists) was designed for health plans and pharmacies to use as a quality improvement platform. IEHP uses EQuIPP to assess the performance of each pharmacy in their network. In this way, IEHP uses the EQuIPP scores to align incentives with their pharmacy network partners to improve patient care.

Pauline: For others who are interested in doing something like this, do they contact PQA or EQuIPP?

Laura: They contact EQuIPP through the company PQS. These value-based or performance-based models are proliferating, so IEHP was probably the first across the country to have a model

like this. Since then, other companies have also created similar models.

Pauline: Do you see this as a trend that PQA started?

Laura: One of the things that PQA does as a non-profit organization is that we often get involved in research-based collaborations, demonstration projects, and pilot programs. PQS evolved out of a demonstration project.

You described PQA's journey from its inception to its current role in medication management. What have been key milestones during this journey?

Laura: The key milestones in the journey over the past eleven years have led PQA to become the "go to" organization when medication measures are being developed.

Milestones:

- The assembly of content experts to address and identify gaps in care

  When we identify a gap in performance measures, PQA can convene the right group of content experts to tackle a measure that needs improvement.

  For example, in the area of multiple sclerosis (MS), there were no existing measures that were nationally endorsed. So PQA stepped in and is working with a group of neurologists to develop the first set of MS measures that can be widely endorsed.

- The expansion and use of our measures by other major programs across the country

  Another California network that uses our program is Integrated Healthcare Associates (IHA). The IHA is a group of over 40,000 physicians that uses our adherence measures in their value-based, performance-based model; they have been using these measures for about six years now. These are the two examples in California; there are many others across the country. California is at the leading edge of current trends in moving away from volume toward value and is implementing some very innovative models.

Who are PQA's key members?

Laura: PQA is a membership-based organization; we have more than 185 members, mostly from health plans, pharmacy benefits management services, pharmacies, and health-systems.

Two large and fast-growing member groups have emerged over the last two years:

- Academic pharmacy institutions

  We now have over 35 academic pharmacy institutions that are PQA members, and the number is growing rapidly. This points to the fact that the future generations of pharmacists need to understand the performance measurement landscape and where it is heading, and the measures by which they will be evaluated when they are working with federal payers, state-based payers, and commercial payers. This trend of the performance-based model is not going away, and it is encouraging to see schools of pharmacy developing curricula that embrace these concepts.

- Health information technology vendors

  The health information technology vendors seek to offer solutions in the marketplace. They see the need to understand and incorporate our measures and measures from other developers into their technology solutions. So, when they are

...future generations of pharmacists need to understand the performance measurement landscape and where it is heading, and the measures by which they will be evaluated...

partnering with a pharmacy, a health plan or a PBM, they need to understand the PQA measures. They often license PQA measures.

Pauline: This segues nicely into fellowship and internship educational programs that are sponsored by PQA. Can you comment on these programs?

Laura: For the past several years PQA has offered a number of different programs.

We offer a one-year fellowship to pharmacy school graduates and other healthcare providers.

We are in the third year of our fellowship program, and I am so pleased to see how these two fellows have advanced in their careers. Both are working on a CMS star rating program and helping their respective clients to understand the measures and make appropriate interventions with patients to improve care.

We also host Advanced Practice Pharmacy Education (APPE) rotations for students in their last year of pharmacy school, processing applications each December to take five students each year.

Pauline: Can you comment on the training curriculum on quality improvement methodology?

Laura: We created EPIC (Educating Pharmacists In Quality), a very extensive quality- and performance-improvement program with over 26 modules designed to be used in two ways:

- by pharmacy schools as a core or elective part of their curriculum, or
- by practicing pharmacists as continuing education.

Which organizations does PQA see as key partners as they continue the journey of improving medication management and patient outcomes?

Laura: We have many key partners in our practitioner-based association which are critical to the work we do. For example, many members of American College of Clinical Pharmacy (ACCP) and American Society of Health-System Pharmacists (ASHP) contribute to the development of our measures.

We have ten different development teams that work actively to develop new measures, and many of those individuals come from major organizations. It is the practitioners that have the clinical expertise that helps to come up with the cutting-edge measures we seek to develop.

Pauline: It's wonderful that PQA is taking the lead in gathering all these leaders from different organizations to work on the same goals.

What do you see as PQA's primary objectives over the next five to ten years?

Laura: One of PQA's primary objectives over the next five to ten years is promoting the recognition that all healthcare is local and, with that in mind, to move some of our measures into our state-based programs. It's a challenge because if I wanted, for example, to have metrics adopted by Medi-Cal the process differs for each state, and that can be a barrier. We have had successes in New York, Washington, and North Carolina, but it is a one-step-at-a-time process. Our focus is not only on developing new measures but what keeps us relevant is needing to stay current with the marketplace as those measures are implemented. That's a key area for us.

The other key area for measure developers in general, and for PQA specifically, is that as more and more providers move to EHRs, we need to develop metrics that can be calculated using the data that already exists within the EHR. These metrics, called e-Clinical Quality Metrics (eCQMs), represent the new frontier in measure development.

Pauline: Do you think e-Clinical Quality Metrics will be in general use in the next five years?

Laura: Absolutely! Hopefully, in the next two years, PQA will have produced its first eCQMs. We also need to develop technical specifications for already-existing measures so that they too can become eCQMs for measuring and tracking the quality of health care services provided by professionals and hospitals.

Over time, PQA and other measure developers will probably retrofit or electronically specify some of our existing measures.

Increasingly as health plans are looking to collaborate with pharmacies, and as quality bonus payments and incentive-based models evolve, pharmacists will need to understand how to use these measures. They will also need to know the measures that are being used by each entity within every program. To participate fully as a quality stakeholder, the pharmacy profession must master the use of clinical quality metrics, and the sooner, the better.

Eleven years ago, when PQA was started and this was all new territory for pharmacists, performance improvement was discussed on a 'need-to-know basis.' Times have changed and, right now, pharmacists and pharmacy students must understand performance measurement and quality improvement. Quality improvement is now routinely done in all healthcare delivery systems – for example, how to prevent an IV admixture error – but performance measurement goes beyond internal quality improvement.

As specialty pharmacy and specialty pharmaceuticals take on an increasing role in contemporary healthcare delivery, will this impact PQA's approach to medication management?

Laura: It already has. Probably two years ago, we recognized a gap in the performance measurement improvement landscape. We created a specialty pharmacy task force, and we have been working on specialty pharmacy measures.

We are now working with clinical specialist groups in the areas of MS, rheumatoid arthritis, and hepatitis C, and have previously worked with human immunodeficiency virus specialists. PQA's work in specialty pharmacy will continue, and the challenge is that there are no specialty pharmaceutical measures today that are incorporated into any federal payer programs. And when these measures do get finalized, the focus will be to get them in the queue and then finding partners in the marketplace to implement them.

Pauline: Is developing these measures more complex compared to the 'regular' measures that you mentioned?

Laura: Specialty measures are more difficult to develop. Sometimes you have certain medications that are administered in the physician's office to treat a condition; that same condition can also be treated with oral agents that are billed under a different system, some under Medicare Part B and others under Part D. So if you need data to develop measures, and it exists in two different payment programs, often it is harder to aggregate. In this way, Specialty measures are not as easy to develop.

What are PQA's key challenges today?

Laura: We have tackled most of the low-hanging fruit – the easier-to-develop measures. Two more difficult tasks lie ahead:

- Drug therapy problem (DTP) resolution: Let's say you had a medication therapy management (MTM) program inside or outside of Medicare. During an MTM session, when a DTP arises, has it been resolved? It is not enough to give someone comprehensive medication review. You also have to ascertain and provide documentation – after 30-, 60-, even 90-days – whether the DTPs that you identified and discussed with the provider have been resolved? We are now dealing with the second and third generation of measures that rely on data that is not in claims data but exists in non-claim-based data.

  Presently, there are numerous MTM providers in the marketplace (e.g., OutcomesMTM®, Merixa®, and Medication Management Services, Inc.). Each has their own propriety platform for documenting and collecting data relative to an MTM sessions. How do you retrieve and aggregate data from all these propriety systems to try to develop a measure? It is not easy.

- Getting data out of the EHR for the development of measures: This one is very challenging. You have EHR systems such as Cerner or EPIC, for whom performance measurement was not a primary deliverable to a health-system client. First-generation EHR systems were not designed to facilitate performance measurement, yet as the use of quality measures is expanding, vendors increasingly will need to provide metrics for performance measurement in their platforms.

We are now dealing with the second and third generation of measures that rely on data that is not in claims data but exists in non-claim-based data.

As pharmacists, we are continuously asked to measure performance. What advice would you give our readers who are involved in developing and tracking performance measures and outcomes?

Laura:

- Get involved where you can in shaping these measures. Do not let someone else determine what should be measured. Pharmacists need to have a voice around the table. We are a multi-stakeholder organization. The voice of the pharmacist is very important.
- Understand the changing landscape. Understand who are driving these changes, which in many cases is the federal government.
- Be knowledgeable about the measures.
- Understand how within the confines of your daily responsibilities and your workflow, how are measurement and quality improvement impacting your practice site? What can you do on behalf of improving patient outcomes to facilitate performance and patient improvement? It is going to change practice over time. Our responsibilities as pharmacists will continue to evolve.

With performance-based measurement, pharmacists sometimes think they need to be compensated for contacting a provider for getting a patient from a high-risk medication to a safer medication to treat the same condition. They want to get paid to have made that change. The way of the future is not to get paid per intervention.

One of the most important lessons to learn from performance measurement is to accept the responsibility for managing a panel of patients. And to look at the panel of patients as an aggregate and to say, "How am I doing with these 200 patients?" In the physician world, a panel of patients is managed from the standpoint of prevention and wellness, in addition to the treatment of chronic conditions. As pharmacists, we must stop thinking we are going to do X and get paid Y, and instead prepare to assume responsibility for managing a panel of patients.

Pauline: You touch upon physicians managing a panel. How do you see pharmacists collaborating with physicians and managing the same population and using these quality measures?

Laura: Today, in accountable care organizations, there are many physicians and pharmacists sharing assumed responsibility in caring for a panel of patients. In many cases, however, as we don't have provider status right now and we can't always bill separately, the services that pharmacists provide are blended in the billing the physician is doing for various federal programs. I think more and more, both physicians and health plans will recognize the value of pharmacists and more fully integrate them into their practice.

Pauline: With the presidential election, do you think there will be major changes to PQA or will PQA continue their current progress?

Laura: I think healthcare reform and the move to these value-based payment models is not going to slow, even if there is a Republican administration in the White House. That train has left the station. I do not think we are rolling back any of the changes that the Affordable Care Act has set in motion.

Pauline: How does measuring quality relate to improving value?

Laura: There is a simple saying, what can be measured can be improved; what can't be measured can't be improved.

A good example is the use of antipsychotics to treat children under five years old. Most of the agents prescribed are not FDA-approved for use in children, and some of these agents have pretty serious side effects. But if we don't broadly measure who is prescribing these medications and why they are selected, and we don't start measuring and trending outcomes subsequent to their use, then we won't have the opportunity to improve the situation or give added value to the patient's care or the provision of healthcare.

If you don't measure an intervention, it can't be improved. It is likely as a result, that its value to society, to the patient and to the healthcare system is not optimized. ○

For more information about PQA, please visit the website at http://pqaalliance.org/about/default.asp.

Introducing the 2015-2016 CSHP New Practitioner Executive Committee

Nicole Yvonne Nguyen, PharmD, BCPS
NPEC Chair

As a group of motivated new practitioners, we are honored to serve on behalf of CSHP and our members. The New Practitioner Executive Committee (NPEC) understands that it will take hard work and perseverance to make a meaningful impact as leaders within CSHP and in the profession of pharmacy as a whole. We aim to engage young professionals and prioritize their involvement in CSHP activities from the local chapters and state level. It is our goal to target the next generation of health-system pharmacists and address the unique needs of young professionals as they transition into their roles as new practitioners. The NPEC hopes to bring new ideas and a fresh perspective to the organization. We recognize the importance to adapt our engagement strategies to attract young leadership, as these new practitioners are essential to the future of CSHP and our profession.

Nicole Nguyen

New Practitioner Year 4 – UCSF Medical Center

Nicole practices as a clinical pharmacist at the University of California, San Francisco (UCSF) Medical Center working within the Neurosurgery, General Surgery, Neurology and Emergency Medicine services. She also serves as an assistant clinical professor at the UCSF School of Pharmacy with teaching and research interests in global health, pharmacotherapy and women's health. Originally from Salt Lake City, Utah, Nicole received her Bachelors of Science in Behavioral Science and Health from the University of Utah. She moved to San Francisco for pharmacy school where she obtained her Doctor of Pharmacy and completed a PGY-1 Pharmacy Practice Residency at UCSF.

Elizabeth Chang

New Practitioner Year 4 – California Pacific Medical Center

Elizabeth (Liz) is currently an antimicrobial stewardship and infectious diseases pharmacist at the California Pacific Medical Center (CPMC). She completed a PGY-2 infectious diseases pharmacy residency at the Kaiser Permanente Oakland Medical Center (2013-2014), completed a PGY-1 pharmacy practice residency at the UCSF Medical Center (2012-2013), and graduated from the University of the Pacific in 2012.

Camille Camargo

New Practitioner Year 3 – St. Joseph's Medical Center

Camille is a practicing pharmacist for St. Joseph's Medical Center. She received a Bachelor of Science degree in Pharmacological Chemistry from the University of California, San Diego and furthered her education with a PharmD degree from the University of the Pacific in 2013. She stayed in Stockton for a PGY1 pharmacy practice residency at St. Joseph's Medical Center where she currently works as a staff pharmacist/emergency room night pharmacist.

Stephanie Luo

New Practitioner Year 4 - Keck Medical Center

Stephanie Luo is a Southern California native who currently resides in the San Gabriel Valley. Stephanie received her bachelor's degree in Biological Sciences and Doctor of Pharmacy from the University of Southern California and subsequently completed her PGY1 pharmacy residency in community practice at Western University of Health Sciences. She currently is a clinical pharmacist at the Keck Medical Center of the USC Downtown Pharmacy.

Hue Nguyen

New Practitioner Year 3 – UCSF Medical Center

Hue is a Minnesota native who currently resides in San Francisco. After completing his Doctor of Pharmacy and Master of Public Administration degrees at Drake University in Des Moines, Iowa, he came to California to complete his PGY-1 residency at Stanford Hospital (2013-2014) followed by a PGY-2 hematology/oncology pharmacy residency at UCSF Medical Center (2014-2015). He is currently a clinical pharmacist at the UCSF Medical Center.

Farzad Daneshvar

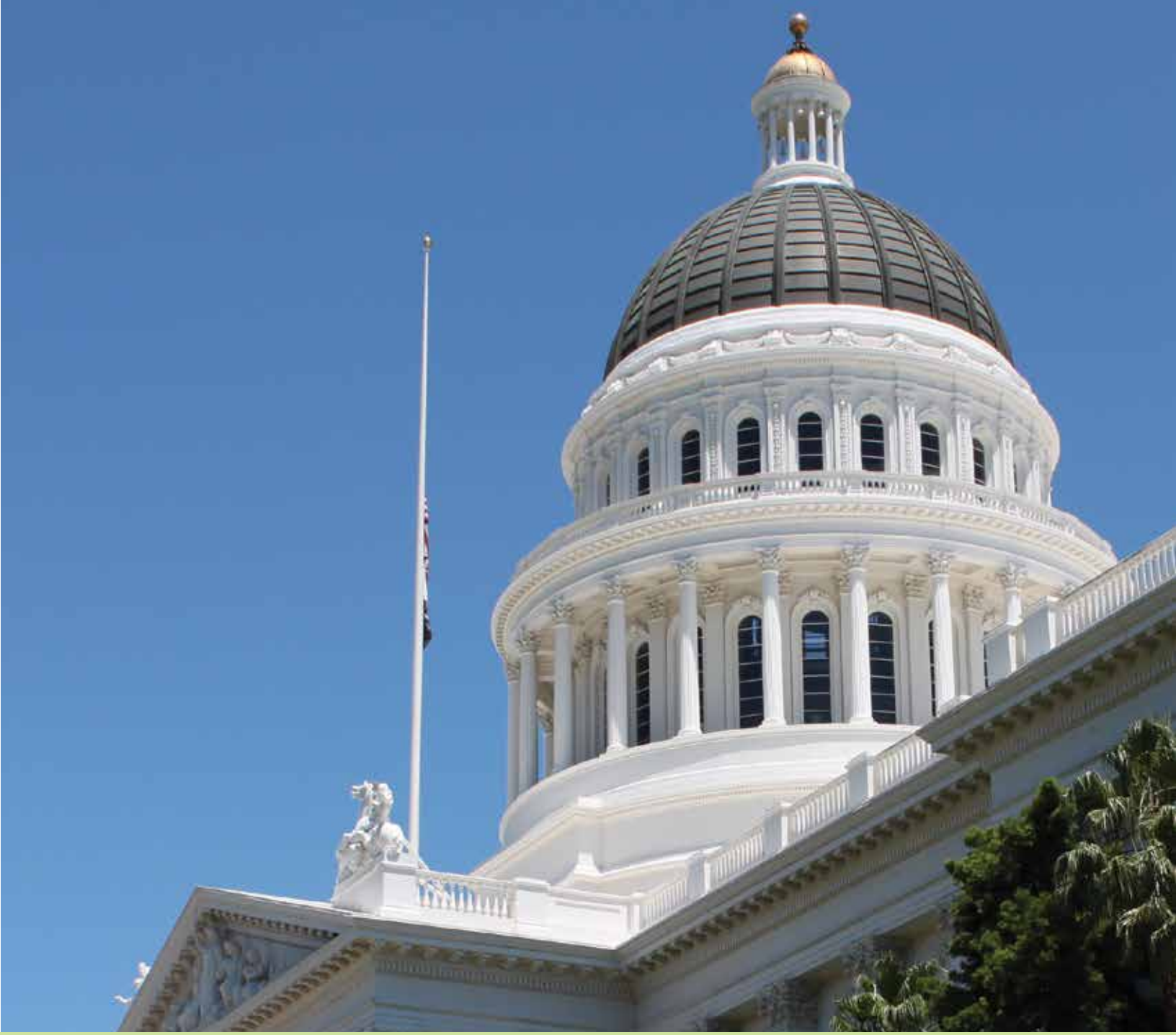
New Practitioner Year 1 – Keck Graduate Institute

Dr. Daneshvar is currently an assistant clinical professor at Keck Graduate Institute School of Pharmacy in Claremont, CA. Before his current faculty appointment, Dr. Daneshvar was a PGY-2 ambulatory care pharmacy resident at Sharp Rees-Stealy Medical Group in San Diego, where he collaborated with primary care physicians and specialists to optimize patients' pharmacotherapies. In addition, he established a new clinical pharmacy service to manage patients on novel oral anticoagulants. Prior to his PGY-2 residency, Dr. Daneshvar completed a PGY-1 acute care residency at Henry Ford Hospital in Detroit, Michigan. Dr. Daneshvar holds a doctor of pharmacy and a B.S. in neuroscience from University of Michigan, Ann Arbor. His research and practice interests include primary care, cardiology, endocrinology, and anticoagulation.

Angela Lee

New Practitioner Year 3 – Veteran Affairs Long Beach

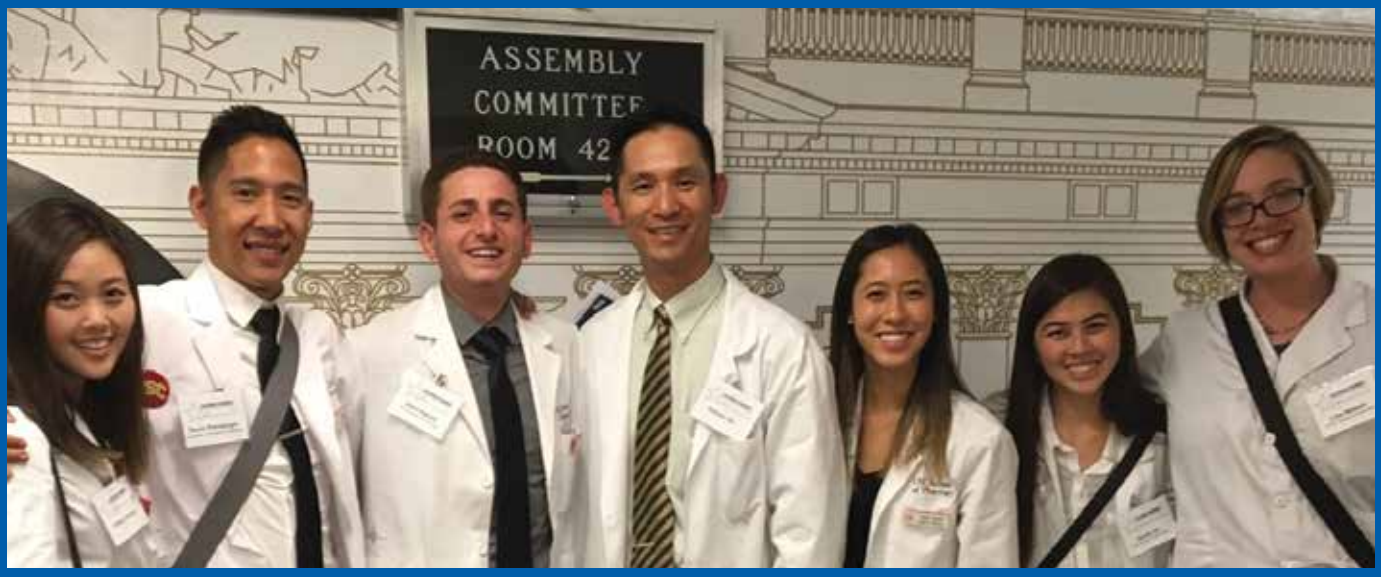
Angela Lee received her PharmD degree from the USC School of Pharmacy in 2013. After graduation, she completed a PGY-1 pharmacy practice residency at the VA Long Beach and has been working there as an ambulatory care pharmacist. Angela currently serves as the secretary, mentorship program coordinator, and delegate for the South Bay-Long Beach chapter. She previously served as the communications co-chair as well. Angela was recognized as the 2014 Resident of Distinction by CSHP and is excited to give forward by serving on the 2016 New Practitioner Executive Committee. Angela enjoys volunteering with pharmacy students at health fairs, working out, traveling, baking, and trying new activities and restaurants through Groupon. ○

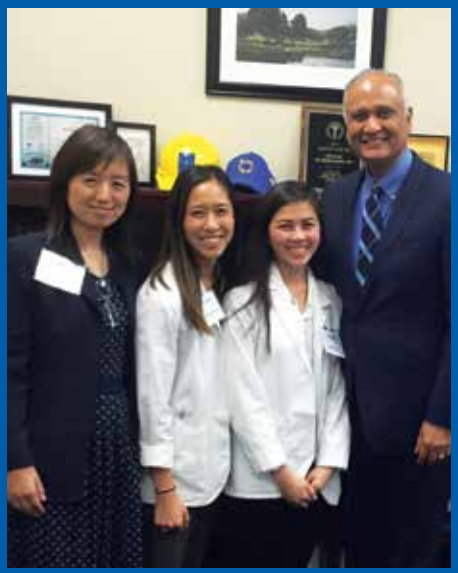


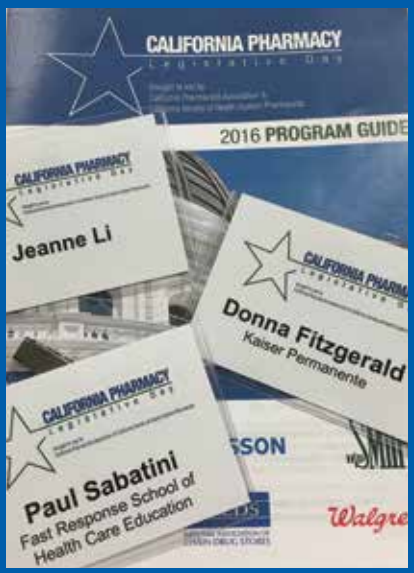
2016 California Pharmacy Legislative Day

The California Society of Health-System Pharmacists (CSHP) and the California Pharmacists Association (CPhA) hosted the annual joint California Pharmacy Legislative Day on April 5, 2016. The event began with presentations and preparations in the morning at the Sheraton Grand Hotel and was followed with a visit to the Capitol in the afternoon.

2016 California Pharmacy Legislative Day







Featured speakers were Assemblyman Brian Maienschein, Assemblyman Jim Wood, Senator Jeff Stone, California State Board of Pharmacy Executive Officer Virginia Herold, CSHP President Kethen So, and CPhA President Sarah McBane.

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