Pharmacies Without Borders

New Skills for Embracing Language and Cultural Diversity in Pharmacies

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En-Vision AMERICA®

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En-Vision America creates products for visually impaired people to better understand and adhere to their prescriptions.

ScripTalk Talking Prescription Labels help visually impaired individuals understand their medication instructions by reading them aloud. First adopted by the U.S. Department of Veterans Affairs, the product has expanded to independent, chain, and hospital pharmacies.

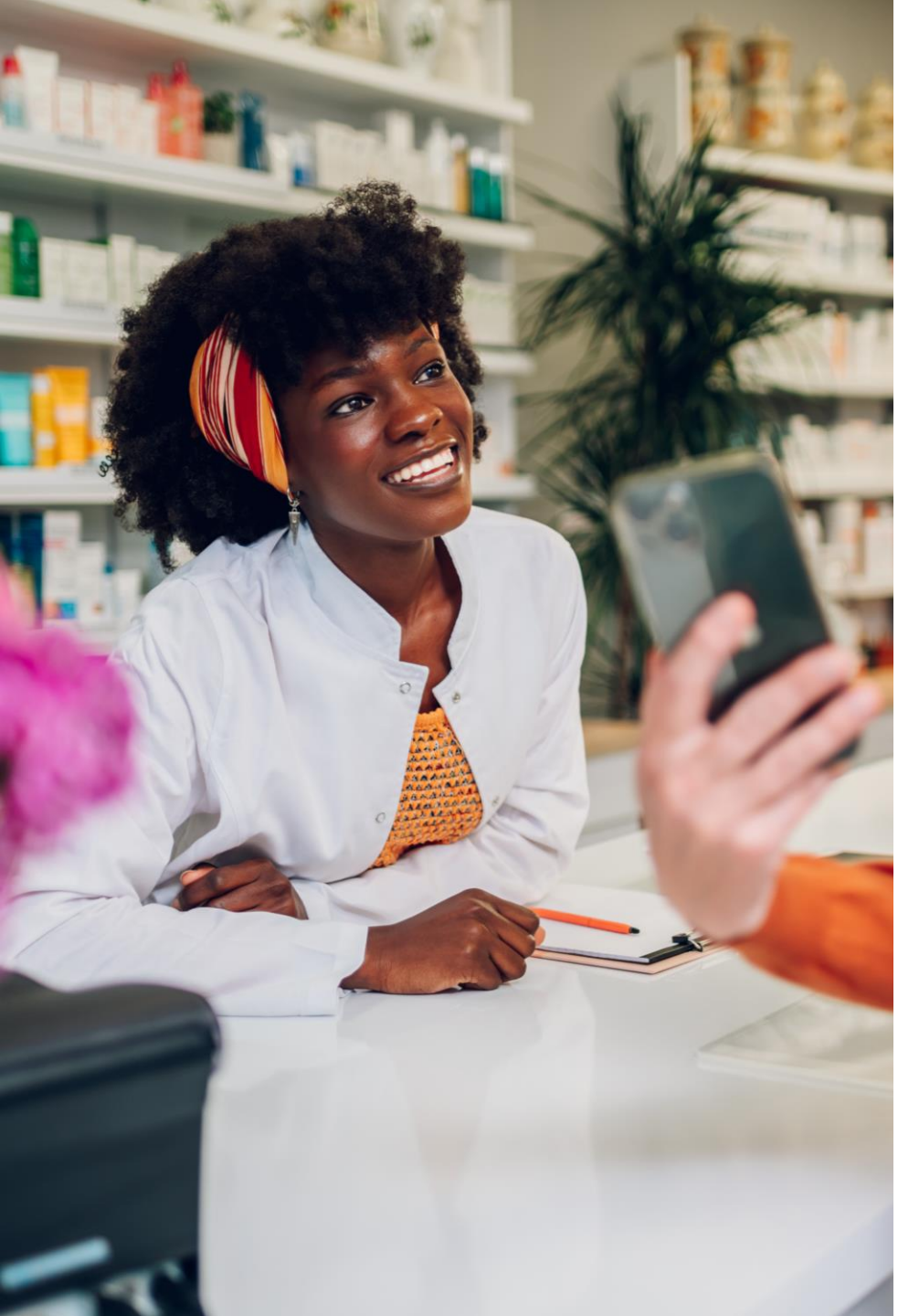
En-Vision America continues to innovate with products like dual-language and video-format labels.

Webinar overview

Since 2016, the Accreditation Council for Pharmacy Education has required pharmacy programs to teach and assess cultural competency so that pharmacists:

- have the ability to practice in diverse environments,
- address ongoing health disparities and
- deliver effective culturally and linguistically appropriate care.

This webinar will examine emerging challenges, best practices, and new legal requirements that pharmacists face as they navigate these issues.



Topics for today

1. Changing demographics and their implications for pharmacies
2. Health disparities and the role of pharmacies in advancing health equity
3. Language access – Current challenges and emerging best practices
4. New regulatory requirements for language access
5. Cross-cultural differences in pharmacy encounters
6. What does the future hold?
7. Questions and answers

Speakers today

Sharla Glass, MA

Community Outreach Liason
En-Vision America

For the last 19 years, Ms. Glass has worked for En-Vision America, advocating for accessible prescription labeling for those who have difficulty seeing or reading. She serves as a community outreach liaison, assisting grassroots advocates with their outreach.

David B. Hunt, JD

Senior Director of Health Equity
BCT Partners, LLC

A former employment law and civil rights attorney, Mr. Hunt is nationally known for his expertise in:

Racial and Ethnic Disparities
Cultural Competence in Healthcare
The Law of Language Access
Global Medicine

Disclaimer

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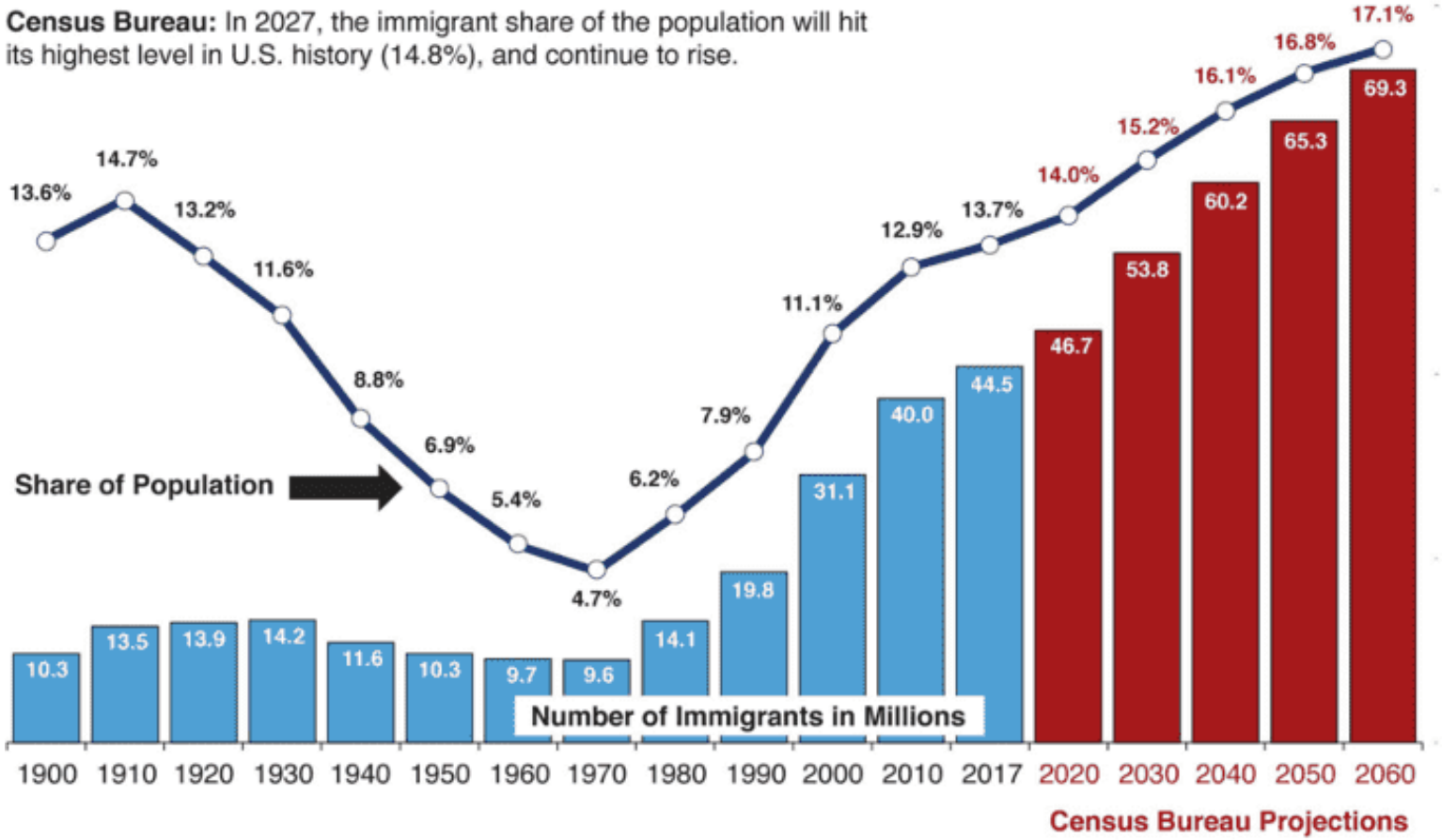
The information provided in this webinar is not a substitute for the advice of a competent attorney. Potential users are advised to seek independent legal counsel to assist them in applying the law to specific healthcare situations.

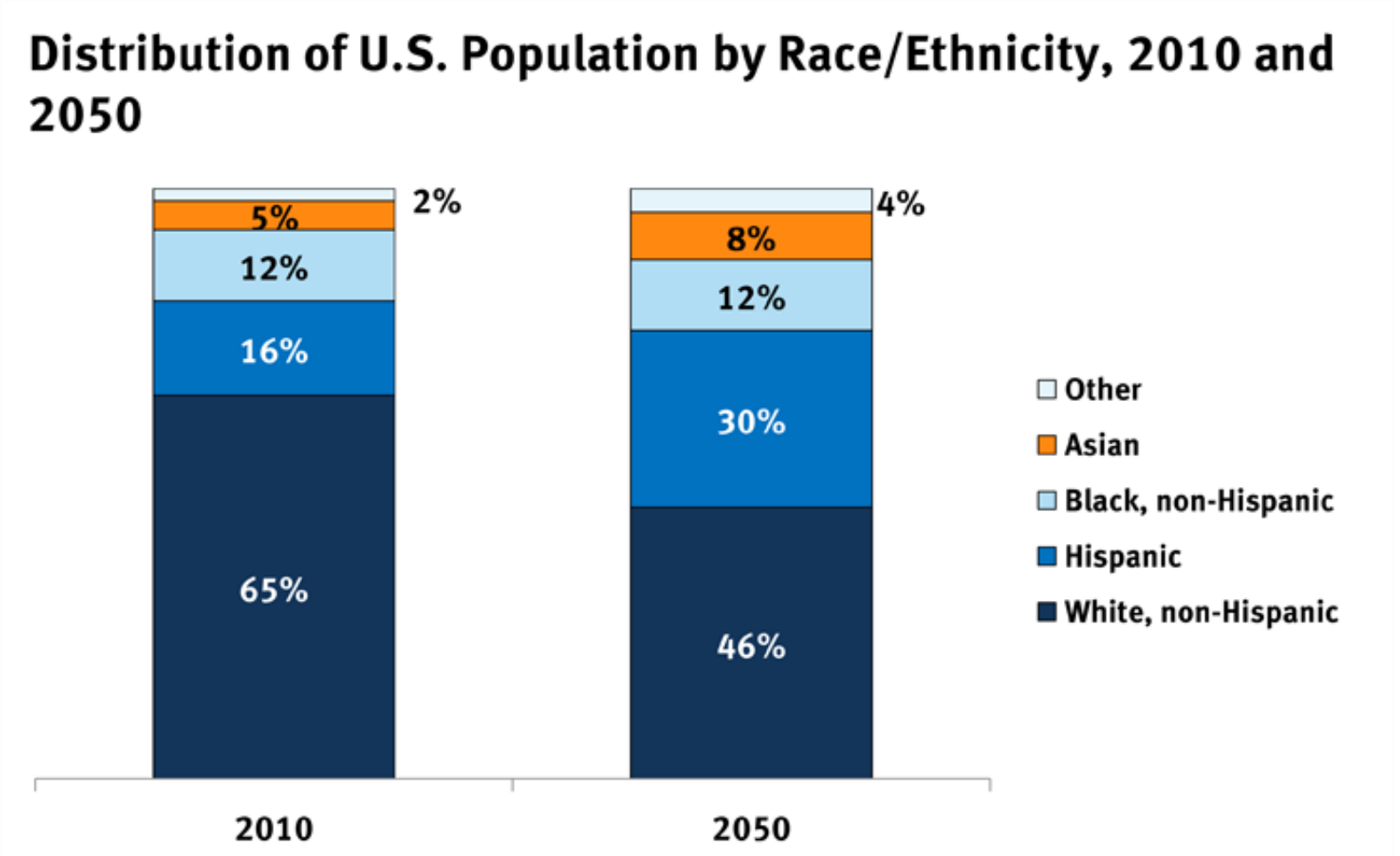
Three demographic megatrends

1. Race
2. Language
3. Immigration & Culture



Center for Immigration Studies. (2017). *Record 44.5 million immigrants in 2017*. Retrieved from https://cis.org/Report/Record-445-Million-Immigrants-2017

Changing demographics – Race



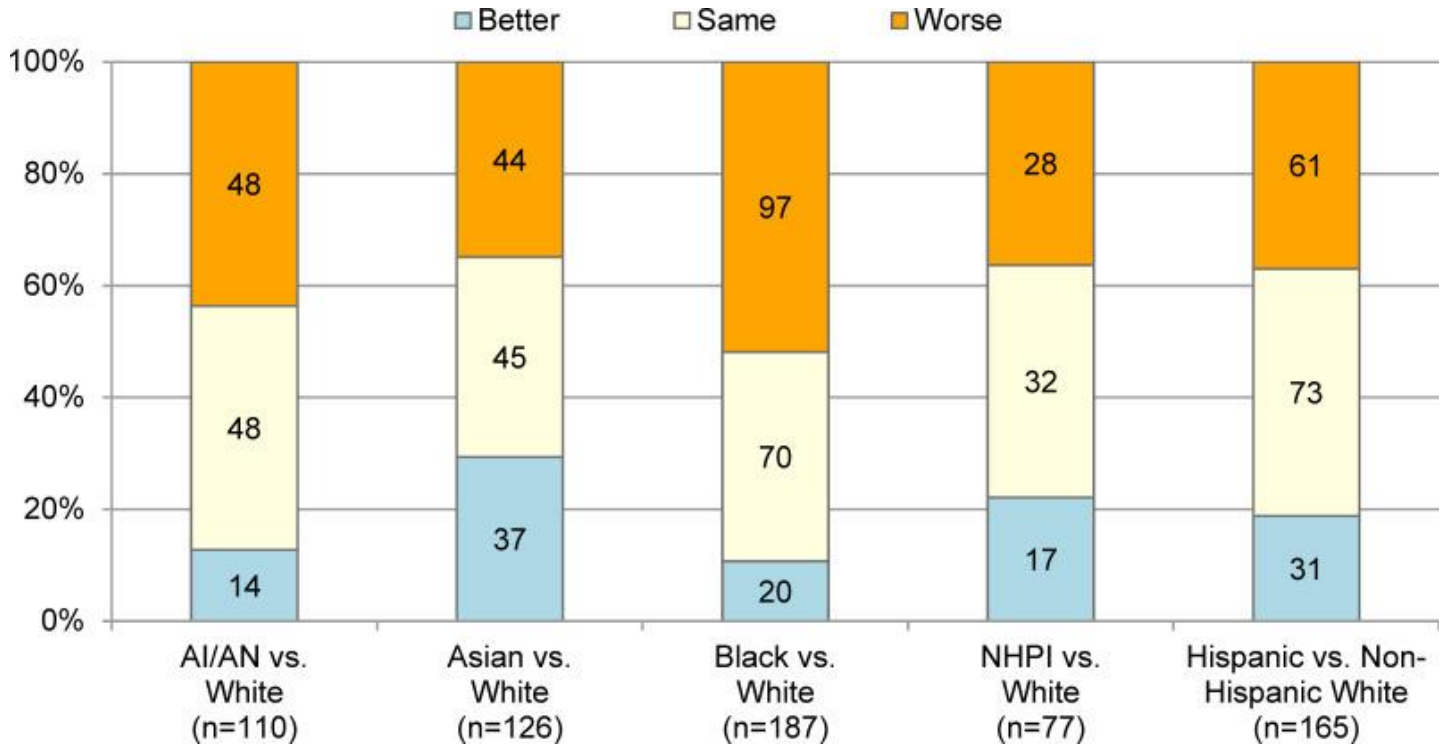
Kaiser Family Foundation. (n.d.). *Distribution of U.S. population by race/ethnicity, 2010 and 2050* [Image]. Retrieved from https://www.kff.org/wp-content/uploads/2013/03/distribution-of-u-s-population-by-raceethnicity-2010-and-2050-disparities.png?w=735&h=551&crop=1

Racial and ethnic disparities have not improved

In 2003, the Institute of Medicine published “Unequal Treatment” which concluded that: “People of Color receive lower-quality health care than whites, even when insurance status, income, age and severity of conditions are comparable.”

Recent studies (2023) by the Agency for Healthcare Research and Quality show that these disparities have not improved and, in some cases have worsened. The COVID pandemic magnified the impact.

Number and percentage of quality measures for which members of selected groups experienced better, same, or worse quality of care compared with White people for the most recent data year, 2019, 2020, or 2021



Agency for Healthcare Research and Quality (US). (2023). *2023 National Healthcare Quality and Disparities Report*. Rockville, MD: Author.

Pharmacies' role in disparities reduction

With more than 60,000 pharmacies across the United States, 90% of people live within 5 miles of a pharmacy, and many offer health services at a lower cost than other providers.

Data show patients see their pharmacists 8 times more often than their primary care providers. Pharmacists can serve people through patient education, counseling, and community outreach.

Pharmacies' role in disparities reduction

Pharmacies can mitigate structural inequality through health care services, such as administering vaccines and providing oral interpreters, written, translated, audible, or Braille drug labels and instructions.

Pharmacy deserts primarily affect communities of color

The Pharmacy Access Initiative, a new interactive mapping tool designed by researchers at the University of Southern California (USC) and the National Community Pharmacists Association (NCPA), will serve as an important resource for policymakers in identifying and addressing where there is a shortage of pharmacies.

Approximately 25% of neighborhoods in the United States are pharmacy deserts, many of which are communities of color. That percentage increases when considering that Medicaid and Medicare recipients must use certain pharmacies.

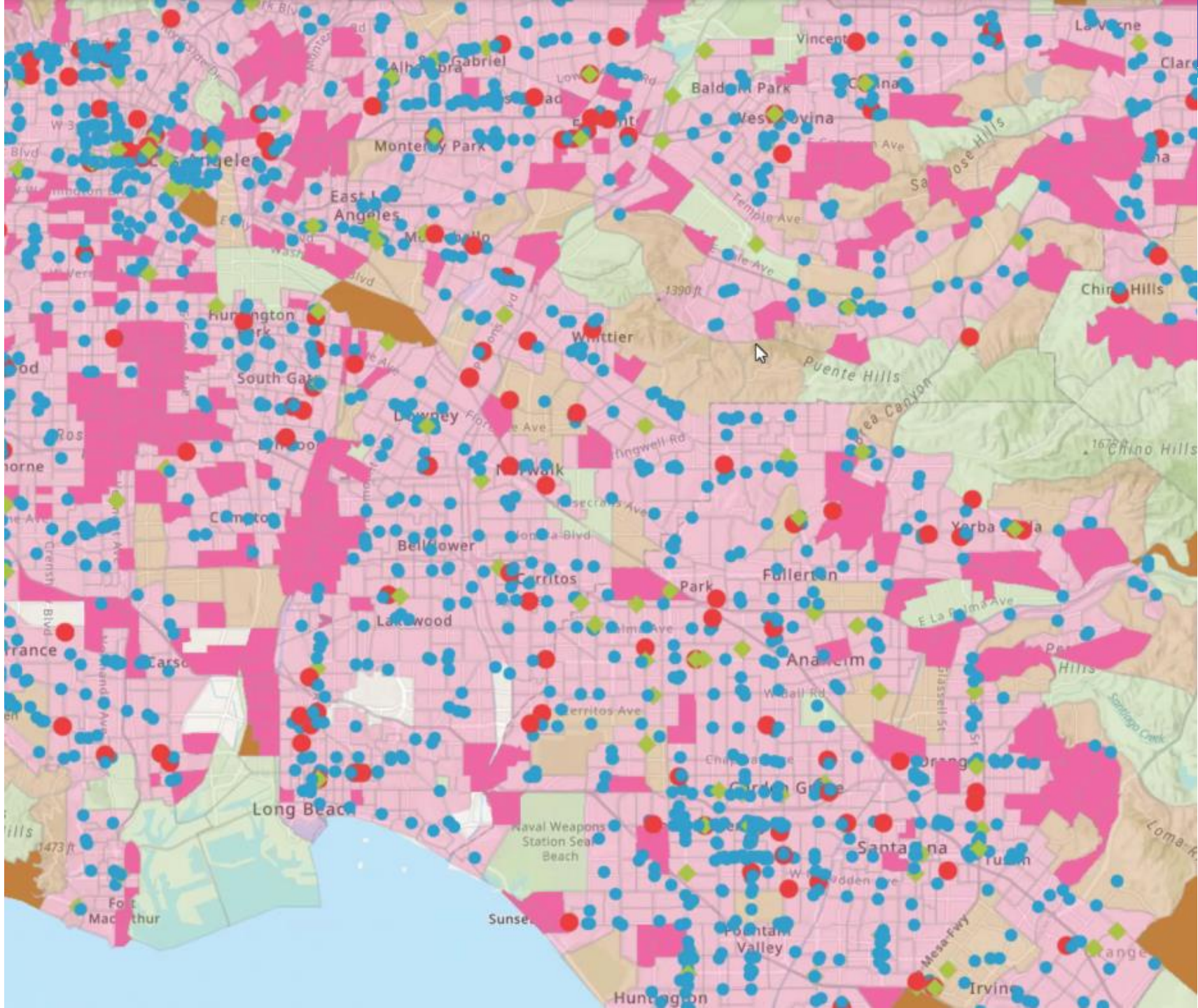
Black and Hispanic neighborhoods have fewer pharmacies, and they are also more likely to experience closures. Research shows that people who have a prescription filled at a pharmacy that subsequently closed are more likely to discontinue their prescription drugs.

INSIGHT Into Diversity. (n.d.). *New mapping tool identifies nation's pharmacy deserts*. Retrieved from https://www.insightintodiversity.com/new-mapping-tool-identifies-nations-pharmacy-deserts/

Pharmacy shortage visualized

The Pharmacy Access Initiative showcases pharmacy shortage areas, many of them in Black and Hispanic neighborhoods. Dark pink and brown areas represent shortage areas in urban and suburban areas.

INSIGHT Into Diversity. (n.d.). *New mapping tool identifies nation's pharmacy deserts*. Retrieved from https://www.insightintodiversity.com/new-mapping-tool-identifies-nations-pharmacy-deserts/



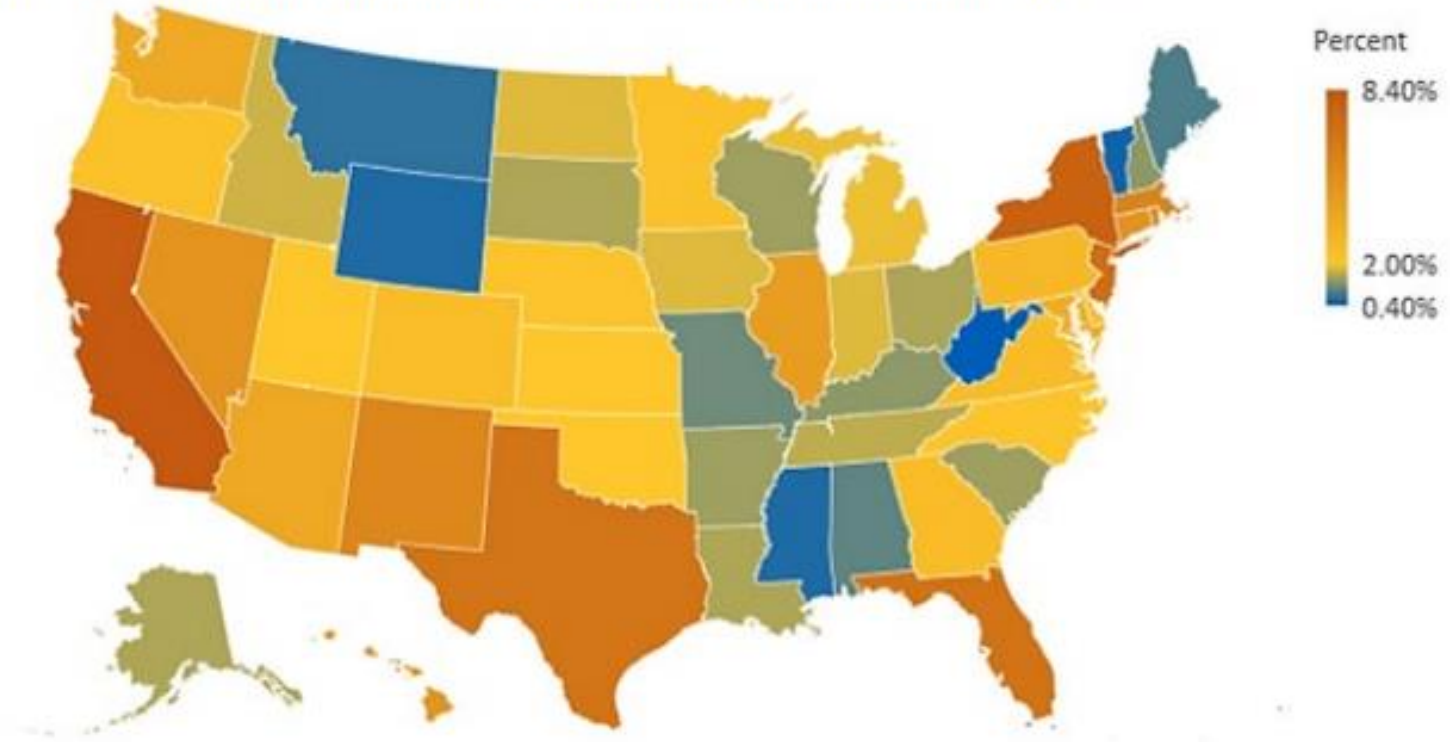
Changing demographics – Language

21.5 percent of U.S. residents (68 million) speak a language other than English at home.

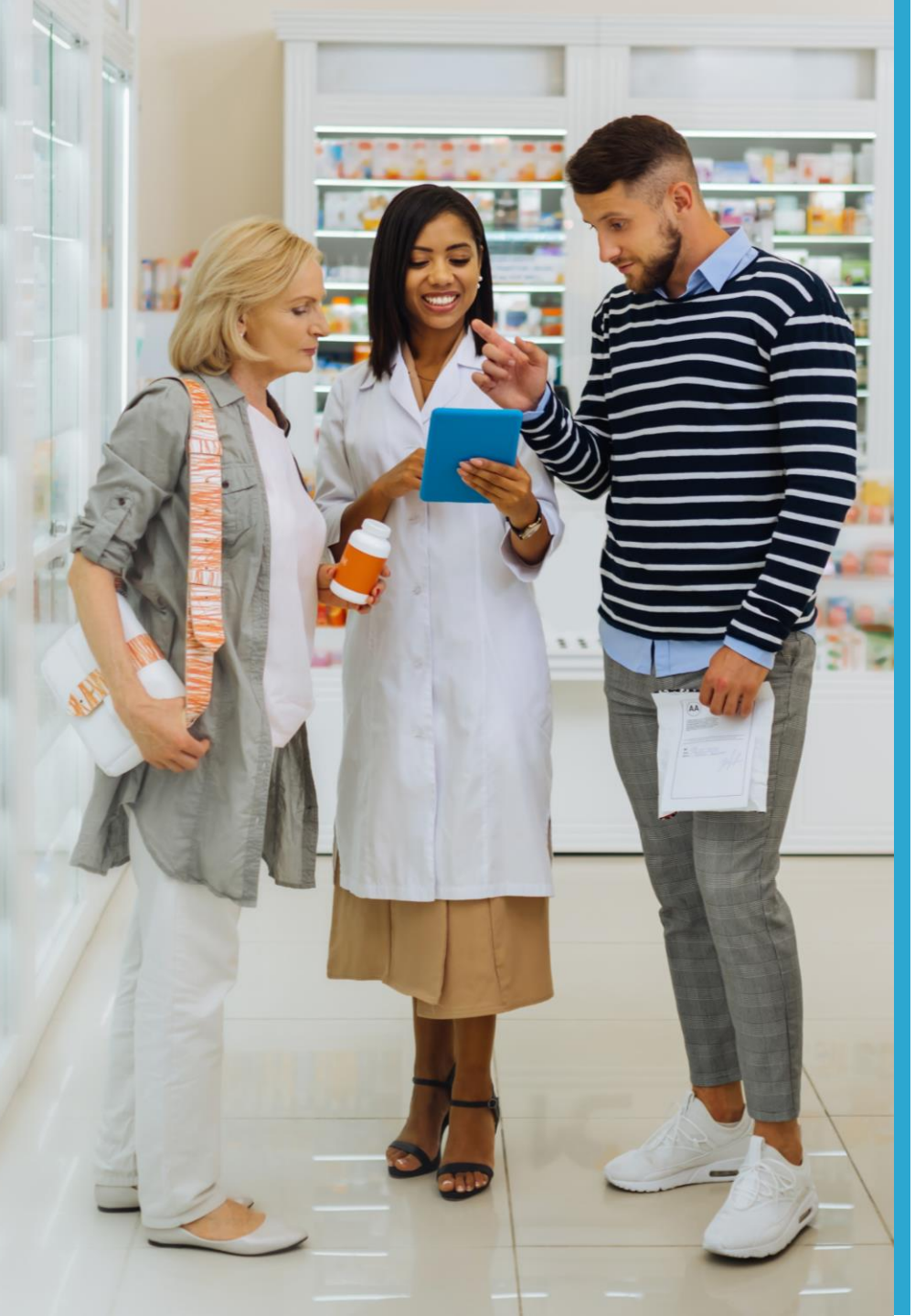
8% of U.S. population (30 million) are limited English proficient and have a legal right to language access services.

Over 350 different languages are spoken throughout the U.S.

Figure 25. Percentage of households with limited English proficiency, 2022



Source: U.S. Census Bureau. American Community Survey 1-year estimates, Table S1602, 2022.



Pharmacies struggled serving LEP patients

- 47% percent of the pharmacies never or only sometimes printed non–English prescription labels.
- 54% never or only sometimes prepared non–English information packets.
- 64% never or only sometimes verbally communicated in non-English languages.
- 11% used patients' family members or friends to interpret.
- Only 55% of pharmacists were satisfied with their communication with patients with limited English proficiency.

Bradshaw, M., Tomany-Korman, S., & Flores, G. (2007). Language barriers to prescriptions for patients with limited English proficiency: A survey of pharmacies. *Pediatrics, 120*(2), e225-e235. https://doi.org/10.1542/peds.2006-3151

A blind patient in a wheelchair waited 1.5 hours beyond her reservation time for paratransit to take her to a pharmacy across town that said it offers accessible prescription labels.

Due to the delay, she arrived near closing time, and the technician informed her that no one had created the accessible prescription labels for her medications; she would have to come back the next day.

The pharmacy closed, and the staff left the patient, who missed doses of essential medications, sitting in her wheelchair, waiting for paratransit to return.

Practical solutions

- Regularly scheduled staff training
- Electronic health record fields and flags
- Translated patient information sheets
- Translated or alternative format prescription labeling
- Interpreter services during counter counseling
- Teach Back Method

Reoccurring staff training

- Cultural competency and accessibility training
- Regularly scheduled and a part of onboarding
- Entire staff, not just pharmacists
- Practice in addition to awareness
- Know how to utilize interpreter, translation, and accessibility services
- Network with community organizations to address social determinants of health

Electronic health records

- Add language preference and accessibility fields in your patient records
- Use pop-up flags to alert pharmacists, techs, and clerks that a patient needs language access or an accommodation.
- NCPDP has already penciled it in as a future SCRIPT standard so prescribers could inform pharmacies of the language access needed along with the prescription.

Patient information sheets

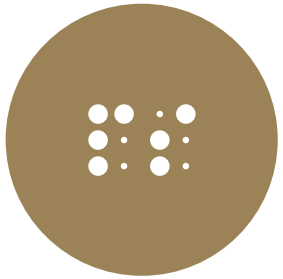
- These should not replace accessible or translated labels directly on the bottle, as they are easily separated.
- Providing patient information sheets in translated format is especially important for drugs with many possible side effects or people with allergies.
- This information might be available through your pharmacy software or the drug manufacturer's website.

Rx Language Access. (n.d.). *Tier 1*. Retrieved from https://sites.google.com/view/rx-language-access/tier-1?authuser=0

Prescription labeling

Even if you provide interpretation, no one remembers everything from a conversation, especially if they are not feeling well, are stressed, or are in a hurry.

Everyone uses prescription label information to know when and how to take their medications.



Ask all patients about their needs periodically. They may lose vision or language ability as they age.

Many refugees don’t read their native language. Ask about oral and written language preferences. You might to offer a talking label for them.

A patient who is blind and uses a guide dog accidentally takes his guide dog's medication. He doses his guide dog with his medication.

Both end up in emergency care.

The patient states that he cares less about his personal medical emergency than about his irreplaceable $25,000 guide dog.

Without this dog, his access would be significantly limited.

Accessible information is

- On the bottle
- Given in a timely manner
- In a format they can access and understand
- Include instructions and warnings

ScriptAbility

Amharic	Farsi	Hindi	Pashto	Somali
Arabic	French	Italian	Polish	Spanish
Bengali	German	Korean	Portuguese (Brazil)	Swahili
Chinese (Simplified)	Greek	Myanmar (Burmese)	Romanian	Tagalog
Chinese (Traditional)	Haitian Creole	Nepali	Russian	Vietnamese

Using an interpreter during counter counseling

- All staff must know how to use language services and partner with an interpreter.
- Patients may be afraid to burden the pharmacy staff. Have a poster or "I speak" point sheet readily available.
- It's not just for the patient to understand you, but for you to know your patient.
- You must ensure you have as unbiased, direct communication as possible. Family members are not unbiased interpreters.

Tips for working with interpreters

1. Position yourself so that you face the patient rather than the interpreter. Maintain consistent eye contact with the patient and stay focused on the patient even while the interpreter is interpreting.
2. Speak in the first person and pause frequently.
3. Avoid medical jargon and acronyms. Check for patient understanding by using the teach-back method.
4. Plan for extra time.
5. Direct your questions or inquiries to the patient.
6. Inform the patient first when you need to ask the interpreter a question and don’t interrupt.
7. It helps to have pre- and post-patient encounter discussions with the interpreter.

We may assume they understand...

Patients leaving the physician's office with a good understanding of what they were told:

Reported by physicians: 80%

Reported by patients: 37%

Source: Intermountain Healthcare Study, 2005

Teach-back method

A communication confirmation technique pharmacists use to ensure that patients understand the information being explained to them.

Here’s how it works:

Explanation:
A pharmacist shared medication details or self-care guidelines with a patient.

Patient Response:
The pharmacist asks the patient to “teach back” what they’ve learned in their own words.

Assessment: The pharmacist listens to the patient’s response. If the explanation is accurate, the pharmacist confirms that with the patient. If there are any gaps, the pharmacist will reteach as needed.

Examples of teach-back starters

I want to make sure I explained everything clearly. Can you tell me in your own words how you will take your medication?

To ensure you understand the plan, can you describe back to me the steps you'll take to manage your diabetes?

Can you show me how you would use your inhaler?

Avoid questions like:

Do you understand?

Do you have any questions?

Poor language access services are linked to:

1. Poor medication adherence
2. Medication errors
3. Permanent physical injury in patients
4. Increases in patient mortality
5. Higher rates of hospital admission, ED utilization, unnecessary medical tests, and higher rates of hospital readmission
6. Breaches in patient privacy and confidentiality
7. Lower patient satisfaction scores

A toddler was taken to a pediatrician’s office by her parents, who spoke no English. The child was diagnosed with iron-deficiency anemia and prescribed an iron supplement.

The parents took the prescription to a local pharmacy that did not provide language services. The prescription label on the bottle was provided in English. The pharmacist attempted to demonstrate the proper dosing and administration. The prescribed dose was 15 mg per 0.6 ml (1.2 ml) daily.

Fifteen minutes after the parents administered the medication to the child, she appeared ill and vomited twice. The child was taken to the emergency room, where it was discovered that the parents had administered 15 ml, a 12.5-fold overdose.

Pharmacists are subject to federal and state language access laws

- Title VI of the Civil Rights Act of 1964
- The Americans with Disabilities Act
- OBRA 1990 – Amending the Federal Medicaid Act
- Health Insurance Portability and Accountability Act (HIPAA)
- Section 1557 of the Affordable Care Act (New 2024)
- Federal and State Drug Labeling Laws
- State Pharmacy Laws – Counseling obligations

What is Section 1557 of the Affordable Care Act?

Section 1557 is an antidiscrimination provision of the ACA relating to healthcare

- Reinforces prior anti-discrimination laws pertaining to race, ethnicity, national origin (language), age, and disability as they apply to healthcare.
- Adds new antidiscrimination protections “on the basis of sex” association, and intersectionality recognizing that individuals may experience discrimination on multiple grounds.

On “the basis of sex” includes/prohibits discrimination:

- Sexual orientation
- Gender identity (including transgender individuals)
- Sex stereotyping
- Sexual characteristics, including intersex traits
- Pregnancy or related conditions (abortion, in-vitro fertilization)
- Marital, parental, or family status

Note: The ACA itself hasn’t changed; only its implementing regulations of Section 1557 have.

Covered Entities include

Entities subject to § 1557 (covered entities) include virtually all healthcare providers:

- Hospitals
- Health clinics (inc. dental and vision)
- Physicians' practices
- Nursing Homes
- **Pharmacies**
- Health insurers/plans
- Home health agencies
- Community health centers
- Federal and state marketplaces
- Refugee resettlement agencies
- State, county, and local agencies (inc. Medicaid, CHIP)

What does the final section 1557 rule require?

1. Appoint a Section 1557 coordinator (entities with 15 or more employees).
2. Train “relevant” staff on Section 1557 (specifically includes C-suite leaders).
3. Develop civil rights grievance procedures (entities with 15 or more employees) and abide by record-keeping requirements
4. Develop specific written policies and procedures to implement non-discrimination requirements and language access programs and procedures.
5. Disseminate Notice of Nondiscrimination and Notice of Availability of Language Assistance Services and Auxiliary Aids and Services
6. Provide written assurances to the Director of OCR that your organization will provide health programs in compliance with Section 1557. Assurances required as a condition of receiving federal financial assistance.

Effective dates

By July 5, 2024

- ❑ Regulations pertaining to Individuals with Limited English Proficiency
- ❑ Regulations with Individuals with Disabilities
- ❑ Regulations pertaining to equal access on the basis of sex
- ❑ Regulations pertaining to telehealth

By November 2, 2024

- ❑ 1557 Coordinator in place
- ❑ Notice of Non-Discrimination published

By May 1, 2025

- ❑ Regulations pertaining to patient care decision support tools (AI)

By July 5, 2025

- ❑ Train “relevant” employees
- ❑ Written policies and procedures implementing the §1557 requirements
- ❑ Notice of Availability of Services and Auxiliary Aids in Services in English and the 15 most common languages spoken by individuals with LEP and accessible in other formats

Covered entities are specifically prohibited from:

1. Requiring individuals to provide their own interpreter.
2. Requiring individuals to pay the cost of their own interpreter.
3. Coercing individuals to decline language assistance services.
4. Coercing individuals to accept language assistance services.
5. Denying language assistance services to “companions” (family member, friend, or associate of person seeking care).
6. Using non-qualified medical interpreters (adult family members and friends) except as a temporary measure in emergencies or if an LEP person requests it.
7. Using minor children as medical interpreters except as a temporary measure in emergencies.

Effective communication with individuals with disabilities

- Communication with individuals with disabilities (including companions) must be as effective as it is with non-disabled individuals.

- Covered entities must develop and maintain effective communication procedures and provide auxiliary aids and services including:

    - qualified interpreters and qualified readers
    - real-time captioning
    - videophones
    - large print
    - audible labels and instructions
    - Braille materials; etc.

Is a pharmacy liable if it does not provide language services to LEP patients?

- Under federal law, OCR investigates complaints against pharmacies and first has an obligation to seek compliance from those who fail to abide by Title VI. If compliance is not obtained voluntarily, OCR may refer the issue to the Department of Justice for formal compliance proceedings that could result in suspension or termination of federal assistance.

- If a patient suffers medical harm caused by a pharmacist, the patient could initiate a malpractice or negligence claim against the pharmacy or pharmacist. If the HIPAA privacy rules are violated, a pharmacy may be liable for fines of $100 per violation, up to $25,000 per year.

- Depending on state law, additional liability may apply. For example, under New York law, failing to abide by the requirements for labeling and counseling could result in a pharmacist facing misdemeanor charges with fines and possible jail time for multiple violations.

How can pharmacies pay for language services?

- CMS recognizes that federal Medicaid and SCHIP funds can be used for language activities and services. States can thus submit the costs of language services needed by Medicaid and SCHIP enrollees to the federal government for partial reimbursement.
- Currently, fifteen states directly pay for language services in Medicaid and SCHIP.
- These states include Connecticut, District of Columbia, Iowa, Idaho, Kansas, Maine, Minnesota, Montana, New Hampshire, New York (only sign language interpreters), Texas (only sign language interpreters), Utah, Vermont, Washington, and Wyoming.
- Some states have limited the reimbursement to “fee-for-service” providers, making managed care plans potentially ineligible. Other states report that they currently set their reimbursement rates for all providers to include the costs of language services as part of the entity’s overhead or administrative costs.

Changing demographics – Immigration and Culture

- By 2019, 13.7% of persons residing in the U.S. were foreign-born, a percentage that increases to 26% when including children.
- The foreign-born population is expected to double by the year 2060, to a total of nearly 78.2 million people.
- Immigrants and their offspring will account for 88% of the population growth over the next 40 years.

Caring for refugees, immigrants and migrants

1. Use qualified medical interpreters.
2. Ask about country of origin and travel history.
3. Know the most common medical conditions, infectious diseases, and parasites.
4. Ask about symptoms of depression, PTSD, and torture.
5. Be aware of alternative medicine and dietary practices.
6. Explore your patient’s explanatory model.
7. Consider spiritual beliefs that impact treatment.

Cross-cultural implications for pharmacies

- Cultural differences in patient expectations: diagnosis vs. symptom relief.
- Cultural differences in medical decision-making.
- Direct vs. indirect communication and conflict style (Saying *Yes* while meaning *No.* Head nodding may mean *I hear you* vs. *I agree with you.)*
- Patients' use of complementary or alternative medicines
- Religious beliefs and practices that can affect patients' use of pharmaceutical drugs
- Preferences for shots vs. pills.

Patient's Explanatory Model

1. Patients' explanatory models of illness are frequently culturally determined, but there are other important influences.

2. Social factors, such as socioeconomic status and education, may shape the conceptualization of an illness.

3. The questions in the textbox to the right were developed by medical cultural anthropologist Arthur Kleinman and can be used to explore the patient's explanatory model.

What do you call this problem?
What do you think has caused your problem?
What course do you expect it to take? How serious is it?
What do you think your sickness does to you? How does it work?
What are the main problems your sickness has caused for you?
What do you fear most about this condition?
What do you fear most about the treatment?

Kleinman, A., & Benson, P. (2006). Anthropology in the clinic: The problem of cultural competency and how to fix it. *The PLoS Medicine*, 3(10), e294. https://doi.org/10.1371/journal.pmed.0030294

Carrillo, J. E., Green, A. R., & Betancourt, J. R. (1999). Cross-cultural primary care: A patient-based approach. *Annals of Internal Medicine, 130*(10), 829-834. Available at: https://fcm.ucsf.edu/sites/g/files/tkssra541/f/Carrillo_CrossCulturalPrimaryCare.pdf

What does the future hold?

The primary care pharmacist and the rise of global medicine

Expanding roles: The primary care pharmacist

- The pharmacy profession is shifting from transactional medication dispensing to a more comprehensive, patient-centered model of care.
- The roles and responsibilities of pharmacists in providing primary care via pharmaceutical care have been outlined by the American Society of Health-System Pharmacists.
- Since 2023, there has been a significant increase in both pharmacists (75% vs. 65%) and other clinicians (29% vs. 26%) who believe pharmacists can take on more primary care duties.
- Evidence suggests that pharmacists integrated into primary care can improve patient outcomes and satisfaction, but their impact on healthcare systems is unclear.

Hayhoe, B., Cespedes, J. A., Foley, K., Majeed, A., Ruzangi, J., & Greenfield, G. (2019). Impact of integrating pharmacists into primary care teams on health systems indicators: A systematic review. *British Journal of General Practice, 69*(687), e665-e674. https://doi.org/10.3399/bjgp19X705461

Globally mobile populations create new paradigms

1.5B travelers cross international borders each year.

Globally mobile populations increase chances of pandemics because of increased spread.

Lack of training in global medicine increases chances of misdiagnosis. Many diseases of foreign origin share the same symptoms as common domestic conditions.

Diseases of foreign origin in the U.S.

Clinicians trained in global medicine are:

- Better prepared to treat globally mobile and minority patient populations.
- More likely to use population-specific clinical best practices when treating globally mobile and minority patient populations.
- More likely to ask key diagnostic questions.
- Much more familiar with infectious diseases of foreign origin.


Q & A

Contact us for help with

- Accessible labeling options

Amanda Tolson, Vice President of Patient Care at En-Vision America, atolson@envisionamerica.com

- Section 1557 compliance (audits, training, consulting)
- Language access audits
- Provider language access practice assessments and benchmarking

David Hunt, Senior Director of Health Equity, BCT Partners, dbhunt@bctpartners.com

Free 30-minute consultation

Resources

The slides and recording will be available on the ScriptAbility.com website starting November 8, 2024.