



PQA SOCIAL DETERMINANTS OF HEALTH RESOURCE GUIDE

for improving
medication use quality





The information included in this guide was obtained from publicly available sources, published literature and in some cases through submission of intervention details directly to PQA and was current at the time it was gathered.

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ABOUT THIS GUIDE

The PQA Social Determinants of Health (SDOH) Resource Guide documents real-world SDOH services that are promising for improving the quality and safety of medication use. The guide focuses on SDOH screenings, referrals and interventions conducted by or involving pharmacists or pharmacies.

We believe this is the first resource guide that catalogues pharmacist and pharmacy-centered SDOH services. The guide provides health care professionals with ideas and examples of SDOH services they can implement. Embedded in the community as the most accessible healthcare providers, pharmacists are uniquely positioned to connect individuals to SDOH resources.

The guide covers services that address seven SDOH barriers, and many of the initiatives profiled address multiple barriers:

- Cost of Medications
- Cultural or Literacy Barriers
- Decent, Safe and Affordable Housing
- Food Security
- Screening for Unmet Needs
- Social Isolation
- Transportation

Meeting patients where they are, the SDOH initiatives come from numerous practice settings and take place at the local, state, regional or national level.

PQA plans to expand and update the guide in the future, as new examples are identified and as existing examples deliver new results. You can submit interventions for consideration through a form on PQA's website.

PQA is grateful for its member organizations' contributions to this guide. The guide's focus was determined at the 2020 PQA Leadership Summit. Participants identified the SDOH barriers where pharmacists are best positioned to provide screening, evaluation and services.

PQA welcomes your feedback on this guide and suggestions on SDOH service elements which can be highlighted in future guide editions. You can share feedback with PQA at anytime by emailing us at Education@PQAalliance.org.

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About PQA

PQA, the Pharmacy Quality Alliance, is a national quality organization dedicated to improving medication safety, adherence and appropriate use. A measure developer, researcher, educator and convener, PQA's quality initiatives support better medication use and high-quality care.

PQA's work includes a focus on the social determinants of health because addressing the complex circumstances in which individuals are born and live is important to advancing medication use quality and helping individuals achieve good outcomes.

A non-profit organization with more than 250 diverse members across healthcare, PQA was established in 2006 as a public-private partnership with the Centers for Medicare & Medicaid Services shortly after the implementation of the Medicare Part D Prescription Drug Benefit. PQA was created because prescription drug programs were a major area of health care where there was no organization or national program focused on quality improvement.

PQA members include pharmacies, health plans, health care providers, pharmacy benefit managers, biopharmaceutical companies, technology vendors, government agencies, associations, health information technology organizations, researchers, accrediting organizations and academia.

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Accountable Health Communities Model

Centers for Medicare & Medicaid Services (CMS)

Keywords: Community services, Medicare and Medicaid beneficiaries, navigation



TYPE OF SERVICE

Screening, Referral

BRIEF DESCRIPTION

The Accountable Health Communities (AHC) Model tests whether identifying and addressing Medicare and Medicaid beneficiaries' SDOH needs will impact health care costs and health care utilization. Community bridge organizations screen beneficiaries and connect them with community services to address SDOH needs.

KEY TAKEAWAY

AHC has screened nearly 500,000 beneficiaries, with early results indicating a 9% reduction in emergency department visits for Medicare fee-for-service beneficiaries.



SDOH AREAS ADDRESSED

Cost of Medications
Cultural or Literacy Barriers
Decent, Safe and Affordable Housing
Food Security
Screening for Unmet Needs
Social Isolation
Transportation



SETTING

Multiple, including health systems and community organizations

LOCATION

United States

SCALE

National



TARGETED POPULATION

Medicare and Medicaid Beneficiaries

INTERVENTION DETAILS

CMS developed the AHC Model, which includes a 10-item screening tool to identify SDOH needs across five domains: housing instability, food insecurity, transportation difficulties, utility assistance needs and interpersonal safety. This tool is appropriate for use in multiple clinical settings, including pharmacies.

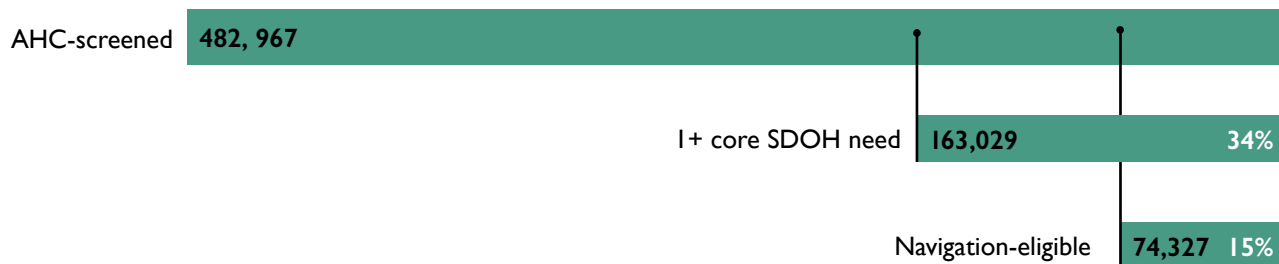
The AHC Model promotes clinical-community collaboration to identify unmet SDOH needs, refer individuals to community services, provide community services navigation assistance and encourage alignment of clinical and community services to ensure responsiveness to the needs of beneficiaries. Implementation of the AHC Model involves collaboration between “bridge” organizations which are community services providers with clinical delivery sites to conduct SDOH screenings, make referrals to community services and assist eligible beneficiaries in navigating community services. Beneficiaries who report at least one core SDOH need and at least two emergency department (ED) visits in the 12 months prior to screening are eligible for navigation services.

From 2017 to 2020, 29 organizations implemented the AHC Model in collaboration with clinical delivery sites, community service providers, state Medicaid agencies and other stakeholders. The evidence-based evaluation of the efficacy of the model is still underway as of October 2021.

OUTCOMES

Between 2017 and 2020, these organization screened nearly 500,000 beneficiaries; 15% of these beneficiaries were eligible for community services navigation assistance. 74% of those eligible accepted community service navigation assistance for help with SDOH needs.

Navigation Eligibility of Screened Beneficiaries



Those beneficiaries eligible for navigation assistance using the AHC model had three times more ED visits and two times more spending in the three years before screening than beneficiaries with one SDOH need but without two self-reported ED visits. Interim results from implementing the AHC model showed a 9% reduction in ED visits among Medicare Fee for Service (FFS) beneficiary enrollees. However, they did not see any Medicare savings or effect on other outcomes in the first year.

RESOURCES

- Centers for Medicare & Medicaid Services. “A Guide to Using the Accountable Health Communities Health-Related Social Needs Screening Tool.” June 2021. Accessed November 19, 2021.
- Centers for Medicare & Medicaid Services. “Accountable Health Communities Evaluation of Performance Years 1–3 (2017–2020).” 2021. Accessed November 19, 2021.
- Centers for Medicare & Medicaid Services. “Accountable Health Communities Model.” October 20, 2021. Accessed November 19, 2021.
- Centers for Medicare & Medicaid Services. “The Accountable Health Communities Health-Related Social Needs Screening Tool.” October 20, 2021. Accessed November 19, 2021.

Addressing Literacy Barriers through Simplified Multilingual Medication Education

First Databank

Keywords: Adherence, English proficiency, HCAHPS scores, hypertension, multilingual, visual disabilities



TYPE OF SERVICE

Intervention

BRIEF DESCRIPTION

Meducation® provides personalized medication instructions through tools such as pictograms, videos and language translations to combat barriers such as low health literacy, failing eyesight, limited English proficiency or reduced cognitive function.

KEY TAKEAWAY

Utilizing Meducation® technology has resulted in improved medication adherence and patient understanding of medication instructions in various healthcare settings. One hospital demonstrated a 70% improvement in 30-day readmission rates for high-risk patients with Meducation® medication instructions compared to standard medication instructions.



SDOH AREA ADDRESSED

Cultural or Literacy Barriers

SETTING

Various

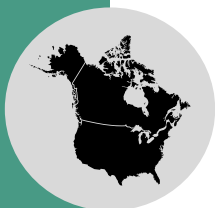


LOCATION

Canada
United States

SCALE

National



TARGETED POPULATION

Individuals with limited health literacy or English proficiency or visual disabilities

INTERVENTION DETAILS

Low health literacy is a significant contributor to communication difficulties between healthcare providers, patients and caregivers. This can lead to medication errors, poor medication adherence and associated consequences, including hospital admissions.

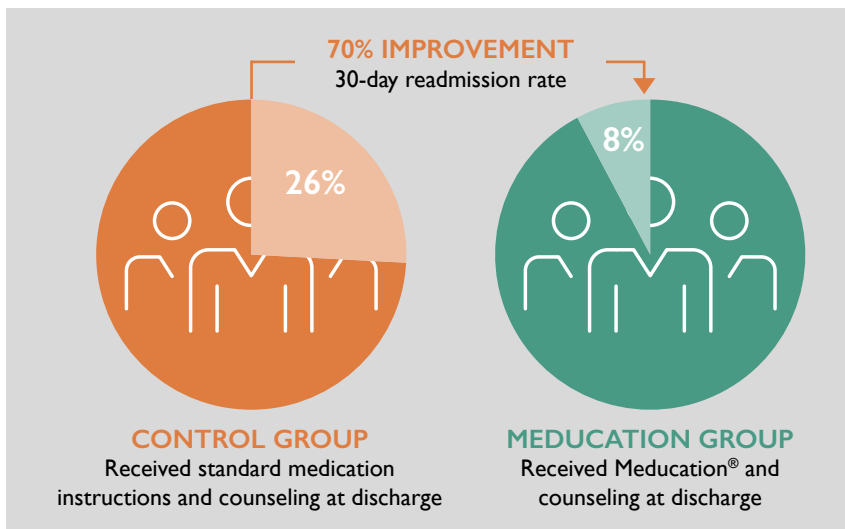
Meducation®, a proprietary cloud-based solution from First Databank, delivers simplified, patient-specific medication instructions for patients with low health literacy, limited English proficiency or visual challenges, using the electronic health record or pharmacy dispensing system to identify patients. Patient education is written at a 5th- to 8th-grade reading level, with large font sizes and in the patient's primary language. In addition to the medication information sheet, patients receive a visual medication calendar that utilizes the Universal Medication Schedule to help patients understand dosing regimens.

OUTCOMES

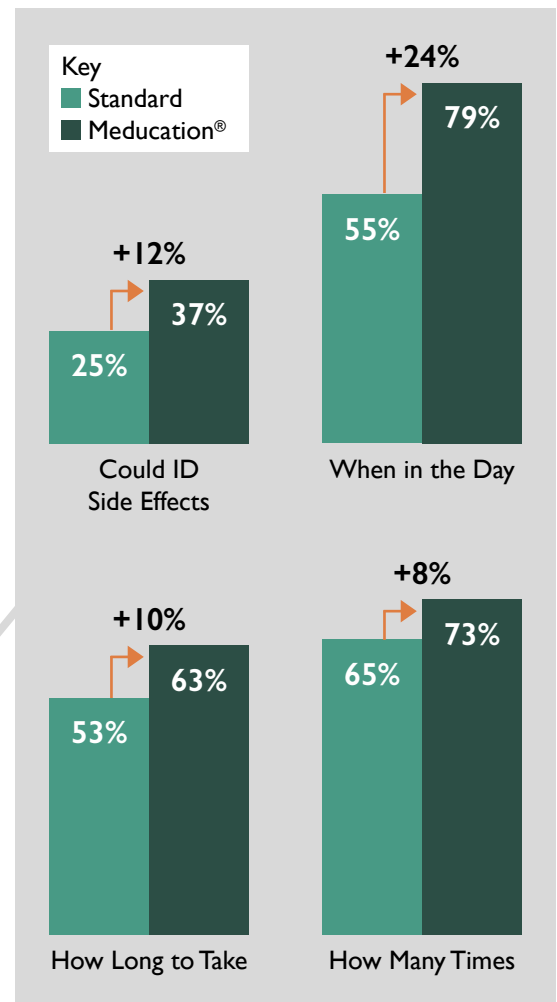
In 2014, a pilot project assessed the impact of Meducation® technology on adherence to antihypertensive medications. After six months, the medication possession ratio improved by 3.2%.

According to a study conducted at the University of the Sciences, patients were twice as likely to read Meducation® instruction sheets over the standard instructions. There was also a 52% increase in medication understanding and adherence after two weeks. Investigators assessed patients on the medication understanding categories of identifying side effects, time of day to take medication, frequency of doses and length of therapy.

Utilizing Meducation® technology has shown improvements in medication adherence, patient satisfaction and readmissions rates in hospitals. For example, at Zuckerberg San Francisco General Hospital, a pilot study demonstrated a 70% improvement in 30-day readmission rates for high-risk patients using Meducation® compared to standard medication instructions.



Two years after implementing Meducation®, Cape Canaveral Hospital's Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores increased from the 27th to the 76th percentile. Additionally, they reached the 92nd percentile for Communication About Medications at the end of year one of the program.



RESOURCES

- First Databank. Case Study Health First. Accessed November 15, 2021.
- First Databank. Meducation Helps Improve Medication Adherence by Addressing Low Health Literacy. 2019. Accessed November 19, 2021.
- First Databank. Zuckerberg San Francisco General Hospital Significantly Improves Readmission Rates with Simple Medication Instructions. 2019. Accessed November 19, 2021.
- Lee, C. "How Community Pharmacists Can Offer Clarity in the Time of COVID-19." LinkedIn. February 9, 2021. Accessed November 15, 2021.
- Meducation website. Accessed November 4, 2021.
- Zullig, L. L., McCant, F., Melnyk, S. D., Danus, S., & Bosworth, H. B. (2014). A health literacy pilot intervention to improve medication adherence using Meducation® technology. *Patient education and counseling*, 95(2), 288–291. doi.org/10.1016/j.pec.2014.02.004

In addition to the resources above, information about this intervention was obtained through correspondence between PQA and First Databank.

Allegheny County Racial and Ethnic Approaches to Community Health (REACH) Initiative

Allegheny County Health Department, Duquesne University Center for Integrative Health, multiple community-based organizations

Keywords: CDC, chronic disease prevention, community-based organizations, diabetes, hypertension, point of care testing



TYPE OF SERVICE

Screening, Referral

BRIEF DESCRIPTION

The Allegheny County REACH Initiative is a community-clinic linkage (CCL) model that allows community-based pharmacists to extend their reach outside traditional health care settings through screening, point-of-care testing and community service referrals.

KEY TAKEAWAY

By utilizing the CCL model, Allegheny County has reached Black communities and helped screen a total of 702 members, with roughly 72% of members referred to other primary care or social services.



SDOH AREAS ADDRESSED

Cost of Medications
Cultural or Literacy Barriers
Decent, Safe and Affordable Housing
Food Security
Screening for Unmet Needs
Social Isolation
Transportation



SETTING

Community pharmacy

LOCATION

Allegheny County, PA



SCALE

Local

TARGETED POPULATION

Black adult community residents

INTERVENTION DETAILS

The REACH Initiative incorporates a community-based screening program for pop-up point-of-care testing for hypertension, diabetes, high cholesterol, cigarette smoking, food insecurity, along with counseling and referral to community services.

The project's leadership team conducted interviews with partner organizations to inform coalition strategies and improve the process for planning and development, implementation, community relationships and recommendations for continuing activities. This coalition consists of more than 25 partners and aims to increase access to healthy foods and physical activities. Community-based pharmacists conduct screenings for SDOH factors and chronic disease before making appropriate social and clinical services referrals. They also followed up with community members to support the CCL model of care access.

OUTCOMES

As of May 2020, community-based screenings led to referrals to clinical and social services outlined below. Between February 2019 and March 2020 in Allegheny County, the program provided health screening and linkages at 63 community events.

Duquesne University School of Pharmacy and the local YMCA offered health screenings and preventative care programs at no cost to participants. Duquesne University School of Pharmacy assisted with COVID-19 testing clinics, offered free chronic disease screenings and health management programs such as diabetes prevention and smoking cessation, and provided flu clinics at various sites.

702 Black community members received at least one health screening and 508 of those community members received a referral to at least one social or clinical service.

Thus far the Allegheny REACH project has resulted in improved awareness of community resources, referral and tracking mechanisms, and coordination of services for individuals.

RESOURCES

Duquesne University School of Pharmacy. "Duquesne University School Of Pharmacy Partners With Allegheny County Health Department REACH For Allegheny Program." July 23, 2020. Accessed October 19, 2021.

Elliott JP, Christian SN, Doong K, Hardy HE, Mendez DD, Gary-Webb TL. Pharmacist Involvement in Addressing Public Health Priorities and Community Needs: The Allegheny County Racial and Ethnic Approaches to Community Health (REACH) Project. *Prev Chronic Dis.* 2021;18:E07. Published 2021 Jan 28. doi:10.5888/pcd18.200490

Live Well Allegheny website. Accessed October 8, 2021.

Pharmacist Roles in Intervention

Pharmacist oversight of community health screening and CCL



Pharmacists provided telephone follow-up with community members

Outcomes

132

Referrals to diabetes prevention program

179

Referrals to smoking cessation program

338

Referrals to established primary care provider

53

Referrals to Food Bank/Just Harvest

Building Pharmacy Capacity to Intervene on SDOH

Community Pharmacy Enhanced Services Network South Carolina (CPESN SC), University of South Carolina

Keywords: Certificate, chronic stress, ongoing study, psychosocial resiliency, risk assessment, training



TYPE OF SERVICE

Screening, Referral, Intervention

BRIEF DESCRIPTION

CPESN SC and the University of South Carolina implemented a program to train community pharmacy teams on key SDOH factors. The program also includes screening patients and an offer to connect patients to relevant SDOH resources.

KEY TAKEAWAY

This program utilizes community pharmacies as a critical access point and leverages their ability to deliver value-based care with training to identify and intervene with a patient's SDOH needs. Twenty-five pharmacies in South Carolina participated and completed 307 intervention plans in the initial four months. SDOH screening found the most prevalent SDOH factors to be social deprivation, health literacy, stress and coping deficits and food insecurity.



SDOH AREAS ADDRESSED

Cultural or Literacy Barriers
Decent, Safe and Affordable Housing
Food Security
Screening for Unmet Needs
Social Isolation
Transportation



SETTING

Community pharmacy

LOCATION

South Carolina



SCALE

State

TARGETED POPULATION

Patients flagged by pharmacy database

INTERVENTION DETAILS

CPESN SC established this three-year program in 2019 and chose 25 of their 52 pharmacies to participate. The focus for each pharmacy will be training assistance, implementation, evaluation and scaling of SDOH services.

The University of South Carolina developed a training course entitled “Addressing Patient Barriers in the Social Determinants of Health,” covering food insecurity, social isolation, chronic stress, and community resources. This course aims to train community pharmacy teams to identify SDOH needs and improve the pharmacy’s capacity to intervene on patients’ behalf regarding these SDOH factors.

In the first year, pharmacy staff complete the training course that identifies patients in need of SDOH screening. Using the data from these screenings, pharmacy staff recommend appropriate referrals. These SDOH factors link to SNOMED codes, and pharmacy staff complete eCare plans on the SDOH interventions.

This program formalizes many of the activities that registered pharmacists are already doing. It leverages the experience, skills and social trust of pharmacists to improve the health of their patients. Future plans include scaling the program to North Carolina.

OUTCOMES

Of 307 SDOH eCare Plans submitted, the SDOH factors identified most often were social deprivation, health literacy barriers, stress and coping deficits and food insecurity. This study is ongoing and aims to publish future analyses.

RESOURCES

American Public Health Association 2020 Annual Meeting. Building the Capacity of South Carolina Community Pharmacies to Intervene on the Social Determinants of Health. Abstract and Slide Deck. October 28, 2020. Accessed October 13, 2021.

Community Health Alignment Article. Building the Capacity of South Carolina Community Pharmacies to Intervene on the Social Determinants of Health. Accessed October 13, 2021.

Foster AA, Daly CJ, Logan T, et al. Addressing social determinants of health in community pharmacy: Innovative opportunities and practice models. *J Am Pharm Assoc* (2003). 2021;61(5):e48-e54. doi:10.1016/j.japh.2021.04.022

307 SDOH eCare Plans submitted

factors identified most often:

social deprivation

health literacy barriers

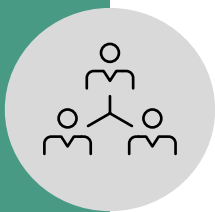
stress and coping deficits

food insecurity

Charitable Donation and Distribution of Medicine

Dispensary of Hope (DOH), fifty medication donors, two hundred dispensing sites

Keywords: Adherence, ongoing study



TYPE OF SERVICE

Referral, Intervention

BRIEF DESCRIPTION

DOH receives donated medications from pharmaceutical manufacturers, then distributes them to partner dispensing sites that supply them at no cost to patients.

KEY TAKEAWAY

DOH's collaboration with Saint Thomas Health resulted in a savings of \$650,000 per 1,000 lives attributed to the partnership. There was a 37% decrease in inpatient utilization, a 20% decrease in average cost per case and a 19% decrease in average length of stay.



SDOH AREAS ADDRESSED

Cost of Medications
Cultural or Literacy Barriers

SETTING

Various



LOCATION

United States

SCALE

National



TARGETED POPULATION

Uninsured patients at or below 300% of the Federal Poverty Level

INTERVENTION DETAILS

Dispensary of Hope (DOH) is a nonprofit licensed drug distributor founded in 2003 as an innovative collaboration between pharmaceutical manufacturers and dispensing sites. DOH partners with pharmaceutical manufacturers to obtain donated medications. DOH then distributes to health systems, clinics and pharmacies, allowing providers to order medications for their patients. Eligible patients receive these medications at no cost to them.



This direct pharmacy-related medication access intervention removes medication cost barriers for patients in need. Today, DOH distributes medications that are Track and Trace compliant under the Drug Supply Chain Security Act to ensure high-quality products for dispensing sites. Currently, they support over 200 dispensing sites in 36 states and the District of Columbia that provide over a million prescriptions per year to patients in need.

OUTCOMES

A 2016 white paper published by the Advisory Board Company analyzed data from Saint Thomas Health in Nashville, TN, one of DOH's partner dispensing sites. The analysis aggregated hospital billing data, DOH pharmacy enrollment data and medication dispensing data. Comparing data from DOH enrollees prior to and following access to medications, there was a 37% decrease in inpatient utilization, a 20% decrease in average cost per case, and a 19% decrease in the average length of stay. The study also identified an annual savings to Saint Thomas Health of \$650,000 per 1,000 enrollees attributed to the partnership with DOH. A study evaluating DOH's impact on multiple health systems is ongoing.

RESOURCES

Advisory Board Consulting. Dispensary of Hope White Paper: Gaining Pharmaceutical Efficiencies, Reducing U.S. Health System Cost, and Improving Health Outcomes by Providing Pharmaceuticals to Those in Need. 2016. Accessed June 3, 2021.
Dispensary of Hope website. Accessed October 25, 2021.

In addition to the resources above, information about this intervention was obtained through correspondence between PQA and Dispensary of Hope.

Embedding Pharmacists in Primary Care Clinics to Increase Medication Access

Ascension Saint Thomas, AscensionRx Community Pharmacies, Dispensary of Hope

Keywords: Adherence, A1c control, chronic conditions, diabetes, interprofessional, telehealth



TYPE OF SERVICE

Screening, Intervention

BRIEF DESCRIPTION

Embedding pharmacists within clinics improve quality metrics for ambulatory care sensitive conditions by removing barriers to optimal medication use.

KEY TAKEAWAY

Ascension Medical Group Saint Thomas embedded pharmacists in clinics utilizing collaborative practice agreements and assisting patients in overcoming medication related barriers to care, including medication cost.



SDOH AREAS ADDRESSED

Cost of Medications
Cultural or Literacy Barriers
Screening for Unmet Needs

SETTING

Health system



LOCATION

Tennessee

SCALE

State



TARGETED POPULATION

Ambulatory clinic patients

INTERVENTION DETAILS

Throughout Ascension Medical Group (AMG) Tennessee, pharmacists are embedded within primary care clinics to support optimal medication outcomes for ambulatory patients.

Pharmacists that serve these clinics receive referrals from collaborating physicians and nurse practitioners to provide comprehensive medication management for patients with uncontrolled chronic conditions, such as diabetes and hypertension.

AMG has partnered with AscensionRx Community Pharmacies and Dispensary of Hope to provide patients with medications at reduced cost to resolve medication access issues. Embedded clinical pharmacy specialists are uniquely equipped to solve these medication access barriers as residency trained, board-certified clinicians who can assess and recommend safe and effective treatments and understand how to address medication access barriers.

Specifically, full-time embedded pharmacists at AMG Saint Thomas Saint Louise Family Medicine Center have a collaborative practice agreement covering multiple disease states including diabetes, heart failure, hypertension, asthma, COPD and hepatitis C. The clinic utilizes in-person and telehealth modalities to successfully complete over 200 encounters monthly. During the COVID-19 pandemic in 2020, pharmacists conducted about 90% of patient visits via telehealth.

OUTCOMES

In 2020, pharmacists working with patients with diabetes at one AMG clinic reduced hemoglobin A1c levels by an average of 2.5% after six months. Additionally, referrals for medication access assistance at that clinic alone provided a value of \$1.3 million in medications.

At Saint Louise, pharmacists report quarterly quality assurance metrics regarding hemoglobin A1c level, blood pressure, heart failure and COPD hospital admissions or readmissions. Annually, pharmacists calculate the number of patients with diabetes whose A1c level is greater than 9%.

In the future, to assess the full impact of pharmacist-provided services, Ascension will aggregate all ambulatory clinic data for pharmacist interventions.

RESOURCES

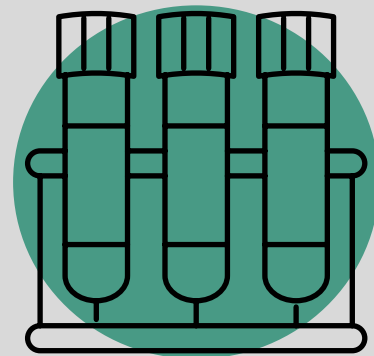
AscensionRx website. Accessed October 22, 2021.

Ascension Saint Louise Family Medical Center website.
Accessed October 22, 2021.

Tennessee Pharmacists Association Committee Spotlight.
“ad hoc Collaborative Pharmacy Practice.” June 5, 2020.
Accessed October 22, 2021.

In addition to the resources above, information about this intervention was obtained through correspondence between PQA and Ascension Saint Thomas.

In 2020, pharmacists working with patients with diabetes at one AMG clinic reduced hemoglobin A1c levels by an average of 2.5% after six months.



Free Transportation to Medical Visits Provided by Health Plan

Blue Cross Blue Shield (BCBS) Institute, Lyft

Keywords: Adherence, COVID-19, health plan



TYPE OF SERVICE

Intervention

BRIEF DESCRIPTION

Nearly 4 million Americans struggle with healthcare access due to unreliable transportation. The BCBS Institute and Lyft partnered nationally to provide BCBS members free transportation to non-emergency medical visits.

KEY TAKEAWAY

The BCBS partnership with Lyft has shown an improvement in care coordination, prevention in emergency department visits, prescription pickup rates and a decrease in appointment no-shows.



SDOH AREA ADDRESSED

Transportation

SETTING

Health plan



LOCATION

United States

SCALE

National

TARGETED POPULATION

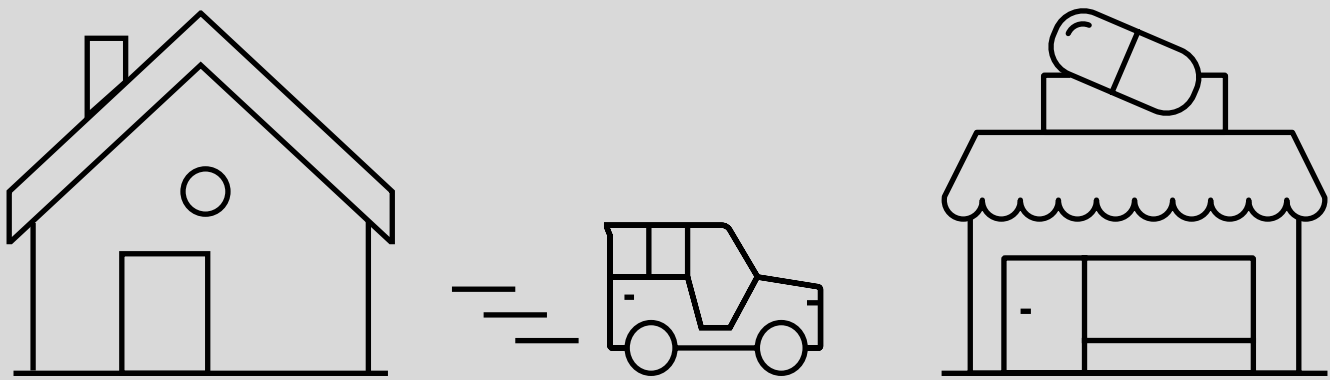
BCBS members



INTERVENTION DETAILS

In 2018 BCBS Institute partnered with Lyft to launch rideQ, which helps members living in areas with limited public transit access and low rates of vehicle ownership with free transportation to non-emergency medical visits. BCBS members of various state specific health maintenance organizations or preferred provider organization plans can self-enroll online in the rideQ program. Members, prescribers or care coordinators can organize individual rides with Lyft. BCBS Institute offers rideQ customer support staff who speak both English and Spanish to enrollees and care coordinators. In 2019, Blue Shield of California launched a year-long pilot program in Sacramento to expand eligible destination options for free member transportation. These destinations include physicians' offices, hospitals, pharmacies, labs and radiology visits and urgent care. Blue Shield of California notified members of their eligibility through personalized emails and letters. Additionally, providers at the Associated Family Physicians, Inc., who participated in the program, discussed rideQ with eligible members during medical appointments.

In 2021, BCBS of Massachusetts and BCBS of North Carolina leveraged their Lyft partnership to provide free rides to COVID-19 vaccination sites. Members could book rides through various channels, including visiting a community health center or contacting a dedicated call center.



OUTCOMES

The implementation of this model has shown an improvement in care coordination, prevention in emergency department visits and a decrease in appointment no-shows. An increase in pharmacy access through this program has resulted in a higher pickup rate for both initial and subsequent prescriptions.

While Blue Shield of California has assessed member adoption rates, consistency and frequency of use and the impact on members' overall health, the results have yet to be published. As of December 2019, BCBS has received high patient satisfaction ratings of 98%.

RESOURCES

Beaton, T. "BCBS Launches Institute to Address Social Determinants of Health." Health Payer Intelligence. March 15, 2018. Accessed November 15, 2021.

Blue Cross Blue Shield. "Blue Cross and Blue Shield and Lyft Join Forces to Increase Access to Health Care in Communities with Transportation Deserts." May 10, 2017. Accessed November 15, 2021.

Blue Shield California. "Non-Emergency Transportation Benefit Frequently Asked Questions." September 2020. Accessed November 15, 2021.

Manos, D. "How Blue Shield of California plans to use Lyft to aid its members." Health Data Management. September 24, 2019. Accessed November 15, 2021.

PQA National Forum. "Caring for the Whole Patient: Leveraging Pharmacists to Address Social Determinants of Health." YouTube. December 19, 2019. Accessed November 15, 2021.

PR Newswire. "Blue Shield of California Debuts rideQ Medical Transportation Program with Lyft in Sacramento for Eligible Members Who Need Rides to Doctor's Appointments." September 18, 2019. Accessed November 15, 2021.

Waddill, K. Payers Partner with Lyft to Expand Coronavirus Vaccine Access. Health Payer Intelligence. March 29, 2021. Accessed November 19, 2021.

HealthTag Initiative

Aetna, CVS Health, Unite Us

Keywords: Community based organizations, health plan, Medicaid, ongoing program, public health, rural



TYPE OF SERVICE

Referral

BRIEF DESCRIPTION

The CVS HealthTag Initiative leverages pharmacist-patient interactions to facilitate communication addressing SDOH factors. Using Aetna claims data analysis, CVS pharmacists provide personalized referrals to community services organized by Unite Us.

KEY TAKEAWAY

CVS Health has partnered with Unite Us and Aetna to provide personalized referrals to patients who may benefit from community services in 47 different locations.



SDOH AREAS ADDRESSED

Cultural or Literacy Barriers
Decent, Safe and Affordable Housing
Food Security
Social Isolation
Transportation



SETTING

Community pharmacy

LOCATION

Louisiana
West Virginia

SCALE

Regional



TARGETED POPULATION

Medicaid beneficiaries



Eighty-six percent of the population lives [near] one of CVS’ 9,900 locations, so they are more likely to go to a pharmacy than go into a health care provider.

RJ Briscione, senior director for social determinants of health strategy at CVS Health



INTERVENTION DETAILS

CVS HealthTag Initiative is part of a more extensive series called Destination: Health which is operated by CVS Health. The HealthTag initiative is a collaboration among CVS Health, Aetna, and Unite Us. Unite Us is a social care coordination platform that connects patients to community-based organizations to meet their specific SDOH needs.

When Aetna Medicaid patients pick up their prescriptions at CVS pharmacies, pharmacists share information about resources available through Unite Us. Included with the medication bag are instructions for enrolling in Unite Us so that patients can access community services for housing, transportation, and nutrition. This program is personalized using Aetna Medicaid data to identify those who need these referrals.

The HealthTag program is in 32 stores in Louisiana and 15 stores in West Virginia with plans to expand.

OUTCOMES

This program is ongoing.

RESOURCES

Blank, C. “CVS Health, Aetna Realize Early Success with Social Determinants of Health Pilot Program.” Drug Topics. December 24, 2020. Accessed October 5, 2021.

Graham, G. “Addressing Social Determinants of Health at the Pharmacy.” US News. November 8, 2020. Accessed October 5, 2021.

Minemyer, P. “Aetna pilot harnesses CVS pharmacists to address Medicaid members’ social needs.” Fierce Healthcare. November 24, 2020. Accessed October 5, 2021.

Unite Us website. Accessed October 6, 2021.

Incorporating SDOH into Telepharmacy Visits

University of North Carolina Eshleman School of Pharmacy

Keywords: Care coordination, completed study, comprehensive medication management, COVID-19, diabetes, patient assistance programs, rural, telehealth, telepharmacy



TYPE OF SERVICE

Screening, Referral, Intervention

BRIEF DESCRIPTION

This study examined the addition of SDOH screening and intervention to comprehensive medication management (CMM) telepharmacy services in rural primary care clinics. Investigators documented pharmacist-led SDOH interventions, assessed stakeholders' feedback on the services and impacts on patients with diabetes.

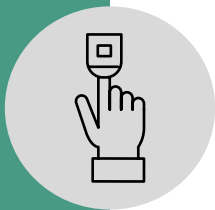


KEY TAKEAWAY

SDOH screening led to pharmacist intervention on multiple SDOH factors. Clinic stakeholders and patients were satisfied with the service.

SDOH AREAS ADDRESSED

Cost of Medications
Cultural or Literacy Barriers
Food Security
Screening for Unmet Needs
Transportation



SETTING

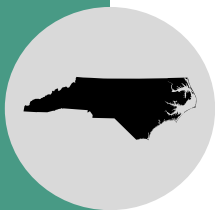
Primary care clinic

LOCATION

North Carolina

SCALE

State



TARGETED POPULATION

Adult patients with diabetes

INTERVENTION DETAILS

This exploratory study assessed the feasibility of including SDOH support within CMM telepharmacy visits. Patients with poorly controlled diabetes in four primary care clinics in rural and underserved North Carolina communities could participate in these visits. Participating clinics did not include SDOH services prior to the initiation of the study.

One part-time clinic pharmacist used a screening tool to assess patients' SDOH needs, including those resulting from COVID-19. The screening tool assessed factors which included employment, transportation needs and access to medications. The pharmacist collected further information on identified SDOH needs and initiated a brief intervention to address them. Interventions included patient education, providing medication coupons, sharing job resources and care coordination.

OUTCOMES

This part-time clinic pharmacist provided 200 telehealth visits for 66 patients over four months, all of which included screenings for SDOH needs. There were 37 needs identified across 27 patients, including employment, health literacy and access to medication. Eleven needs were addressed prior to screening, and the pharmacist provided support through brief interventions for the remaining 26.

The clinic team reported that the pharmacist's SDOH services were beneficial and were satisfied with the pharmacist's services. They noted challenges with a lack of reimbursement for the SDOH services.

Patients reported positive experiences with telepharmacy visits and increased confidence in having their SDOH needs met, including increased access to medications. Patients also reported increased diabetes quality of life.

RESOURCES

Livet M, Levitt J, Lee A, Easter J. The pharmacist as a public health resource: Expanding telepharmacy services to address social determinants of health during the COVID-19 pandemic. *Explor Res Clin Soc Pharm.* 2, 100032. doi: 10.1016/j.rcsop.2021.100032

Pharmacist-Provided SDOH Interventions

Patient Education

- Exercise
- COVID-19 Testing
- COVID-19 Vaccines
- Limiting Exposure to COVID-19

Referral to Community Resources

- Grocery delivery
- Medication coupons
- Job information

Care Coordination

- Referral to pharmacy offering delivery
- Patient assistance programs

Integrating SDOH into Comprehensive Medication Management

University of Minnesota College of Pharmacy

Keywords: Behavioral health, coaching, completed study, comprehensive medication management, health consultant, medication therapy problems



TYPE OF SERVICE

Screening, Referral

BRIEF DESCRIPTION

Two pharmacists, providing comprehensive medication management (CMM) in a behavioral health clinic, integrated SDOH into CMM visits. Pharmacists received introductory SDOH training and regular coaching calls to refine SDOH incorporation into CMM. Researchers conducted qualitative analyses to evaluate the pharmacists' experience with the initiative.



KEY TAKEAWAY

SDOH training and coaching calls helped increase pharmacists' awareness of SDOH factors experienced by their patients, and documenting SDOH factors helped form linkages between SDOH and medication therapy problems (MTPs). Pharmacists expressed that many SDOH factors identified would have come up naturally but found that recognizing and defining SDOH factors supported a clear understanding of impacts on patients' health status.



SDOH AREAS ADDRESSED

Cost of Medications
Cultural or Literacy Barriers
Decent, Safe and Affordable Housing
Food Security
Screening for Unmet Needs
Social Isolation
Transportation

SETTING

Outpatient behavioral health clinic

LOCATION

Midwest



SCALE

Local

TARGETED POPULATION

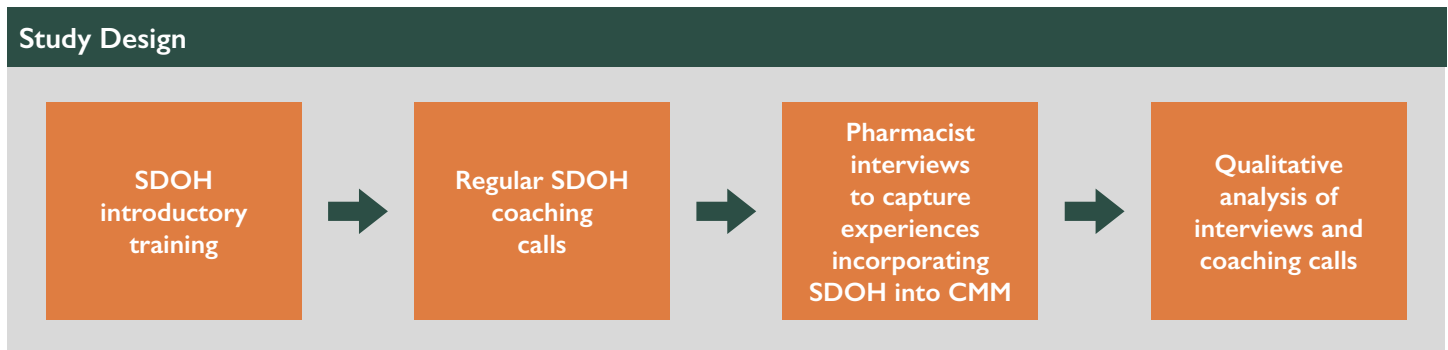
Patients receiving CMM at a behavioral health clinic

INTERVENTION DETAILS

In 2018, one outpatient behavioral health clinic selected two residency-trained pharmacists to receive a 45-minute introductory presentation on SDOH. They also received SDOH coaching calls from a consultant with expertise in quality improvement and implementation for the following ten months. These calls support the pharmacist to incorporate SDOH into CMM in-person or telephonic visits.

If SDOH factors arise during CMM visits, pharmacists ask open-ended questions to learn more about the specific factor(s). During their coaching calls, the pharmacists discuss SDOH factors to evaluate how SDOH may directly relate to MTPs, such as nonadherence.

After the study period, the pharmacists were interviewed to assess their experience incorporating SDOH into CMM visits. Coaching calls and interviews were recorded and qualitatively analyzed.



OUTCOMES

Descriptions of the experience and perceptions to incorporate SDOH into CMM visits were coded and linked to the Pharmacists' Patient Care Process steps, such as collecting information about the patient, assessing the information collected and developing a patient-centered plan.

Pharmacists felt it was best to ask open-ended questions about SDOH related to medication use. Initially, pharmacists struggled to link SDOH to MTPs but gained competency through coaching calls and experience. Pharmacists expressed that they may have identified these SDOH factors naturally, but the increased focus on SDOH increased understanding of overall health impact.

An additional study is needed on incorporating SDOH into healthcare visits, including CMM.

RESOURCES

Joint Commission of Pharmacy Practitioners. "The Pharmacists' Patient Care Process." 2021. Accessed November 17, 2021.

Pestka DL, Espersen C, Sorge LA, Funk KA. Incorporating social determinants of health into comprehensive medication management: Insights from the field. *J Am Coll Clin Pharm.* 2020; 3: 1038– 1047. doi.org/10.1002/jac5.1254

Patient Assistance for American Indian Patients

Cass Lake Indian Health Service (IHS)

Keywords: Adherence, patient assistance program



TYPE OF SERVICE

Referral, Intervention

BRIEF DESCRIPTION

Cass Lake IHS launched the Patient Assistance Project in 2019, which utilized designated pharmacy staff to help patients access high-cost medications and reduce pharmacy medication costs.

KEY TAKEAWAY

Cass Lake IHS pharmacy enrolled at least 60% of eligible patients in patient assistance programs, resulting in increased medication access and an annual pharmacy cost savings of over \$80,000.



SDOH AREA ADDRESSED

Cost of Medications

SETTING

Critical access hospital and outpatient ambulatory care clinic pharmacy



LOCATION

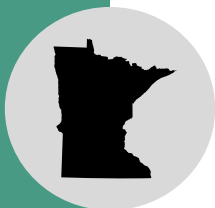
Leech Lake Indian Reservation in Northern Minnesota

SCALE

Local

TARGETED POPULATION

American Indian population; patients uninsured outside of IHS services



INTERVENTION DETAILS

The Cass Lake Indian Health Service (IHS) pharmacy started the Patient Assistance Project in 2019 to help with high-cost medications. This project aims to help patients receive prescription medications and decrease the overall costs of medications for the pharmacy.

The Cass Lake IHS pharmacy is part of a federally funded public health service unit that serves the American Indian population, located on the Leech Lake Indian Reservation in Northern Minnesota. Many of their patients are low-income earners and live below the poverty line. Most patients qualify for public health assistance programs such as Medicaid; however, a portion of people remain uninsured for healthcare services outside of IHS. Located in a remote area, Cass Lake IHS patients also face the challenge of accessing healthcare facilities as this requires traveling and a mode of transportation. These factors make the facility an important access site that patients rely on to receive the healthcare and medications they need. Cass Lake IHS pharmacy staff provides medications to eligible patients at no cost.

Due to the complex health needs of their patients and as a result of new, expensive and required treatments, Cass Lake IHS pharmacy must decide on the best ways to obtain these prescription medications while remaining within their allocated funds. Pharmaceutical manufacturers offer patient assistance programs that provide high-cost medications for free to patients who do not have prescription coverage or cannot afford them. These programs have eligibility criteria that applicants must meet and require proof of income, lack of prescription coverage, or ineligibility for public assistance.

To reduce medication costs while still maintaining quality care, pharmacy staff assist patients in enrolling in patient assistance programs. Cass Lake IHS pharmacy designates specific pharmacy staff that identifies eligibility for each patient assistance program, gathers required documentation, fills out paperwork and submits the completed applications. Once approved for the patient assistance program, the manufacturer will mail the medications to Cass Lake IHS pharmacy. Patients pick them up along with their other prescriptions or pick up after a provider visit, where they also receive one-on-one counseling.

OUTCOMES

The pharmacy Patient Assistance Project to procure free medications from pharmaceutical patient assistance programs has increased access for needed high-cost medications for Cass Lake IHS pharmacy patients. It has also helped cover medication costs for the pharmacy so that pharmacy staff may continue to provide services to patients.

In 2020, Cass Lake IHS pharmacy achieved the goal of enrolling at least 60% of eligible patients in a patient assistance program, resulting in a pharmacy cost savings of \$80,021.52 or 2.29% of the annual budget. Therefore, a pharmacy-run Patient Assistance Project and pharmaceutical patient assistance programs have made a significant impact by allowing Cass Lake IHS to meet patients' prescription medication needs and defraying medication costs.

RESOURCES

Information about this intervention was obtained through correspondence between PQA and the Cass Lake Indian Health Service. For more information about Cass Lake IHS, visit: www.ihs.gov/bemidji/healthcarefacilities/casslake/

Outcome

Enrolled at least
60%
of eligible patients

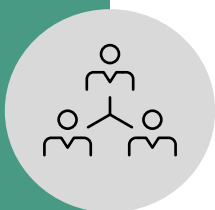
Outcome

Pharmacy cost savings of
\$80,022
or **2.29%**
of the annual budget.

Pharmacist-Managed Prescription Delivery and Home Visitation Service

Ohio Northern University (ONU)

Keywords: Disease state management, MTM, ongoing study, personalized care, point of care testing, preventative health, rural, students

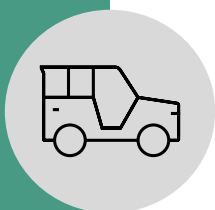


TYPE OF SERVICE

Screening, Referral

BRIEF DESCRIPTION

Healthwise Pharmacy, operated by ONU's College of Pharmacy, utilizes home visits as a means to increase access to care and deepen the understanding of the community patient population and their healthcare needs.



KEY TAKEAWAY

Rural communities face access barriers, including those related to workforce shortages and transportation. This ongoing study is assessing pharmacists' roles in addressing SDOH factors in rural communities and evaluating the impact those services have on hospital readmissions and point of care testing values.



SDOH AREAS ADDRESSED

Cost of Medications
Cultural or Literacy Barriers
Decent, Safe and Affordable Housing
Food Security
Screening for Unmet Needs
Social Isolation
Transportation

SETTING

Rural community pharmacy

LOCATION

Hardin County, OH

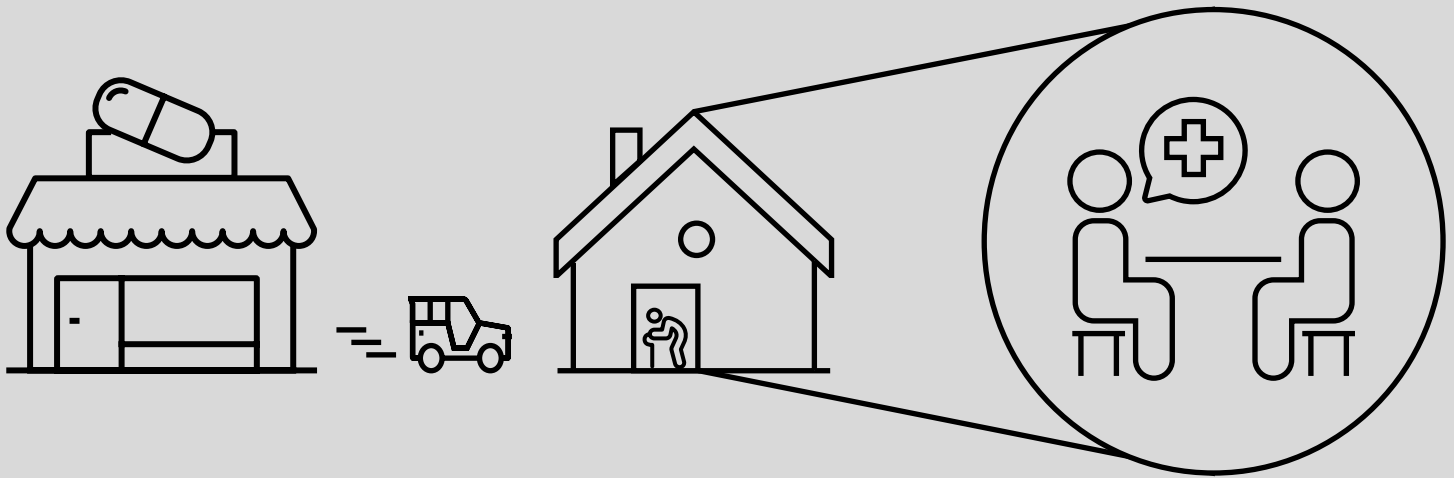


SCALE

Local

TARGETED POPULATION

Adult ONU Healthwise Pharmacy patients with at least one chronic disease state such as diabetes, hypertension or dyslipidemia



INTERVENTION DETAILS

Individuals in Hardin County, Ohio, may elect to participate in home visitation services from pharmacy personnel and agree to additional follow-up throughout this study. Participants complete an SDOH survey assessing their socioeconomic needs. Pharmacy personnel review the individual's needs and determine priority areas to address. Home visitation services include medication therapy management (MTM) and education conducted by a pharmacist and a student pharmacist. If appropriate, pharmacists will conduct point of care testing for chronic conditions. This study is assessing pharmacists' roles in addressing SDOH factors in rural communities and evaluating the impact SDOH services have on hospital readmissions and point of care testing values.

OUTCOMES

This study is ongoing.

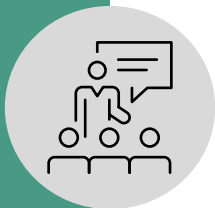
RESOURCES

Musser, M. "ONU health-care outreach efforts enhance quality of life." *The Lima News*. July 18, 2019. Accessed October 19, 2021.
Ohio Pharmacy Resident Conference, May 15, 2020. Implementation of a Pharmacist-Managed Prescription Delivery and Home Visitation Service in a Rural Community. Accessed October 8, 2021.
ONU Poster, December 2019. Healthwise Implementation of Pharmacist-Driven Prescription Delivery (December 2019). Accessed October 8, 2021.
Steiner, F. "Pizza inspires ONU prescription delivery service." *Ada Icon*. February 17, 2020. Accessed October 19, 2021.

Pharmacist Partnership with Local Barbershops to Reduce Blood Pressure in Black Men

National Heart, Lung, and Blood Institute (Clinical Trial)

Keywords: Barbershop, collaborative practice agreement, completed study, hypertension, race



TYPE OF SERVICE

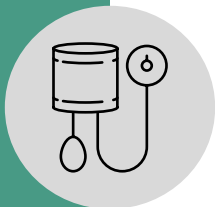
Intervention

BRIEF DESCRIPTION

Health promotion by local barbers encouraged access to specialty-trained pharmacists for communities often underrepresented in health care interventions.

KEY TAKEAWAY

In this study, the majority of Black men achieved goal blood pressure when pharmacists worked with trusted community members. The study demonstrated how increased accessibility to pharmacists could lead to positive patient outcomes.

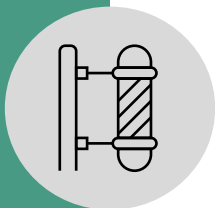


SDOH AREAS ADDRESSED

Cultural or Literacy Barriers
Race

SETTING

Non-traditional health care



LOCATION

Los Angeles County, California

SCALE

Local



TARGETED POPULATION

Non-Hispanic, Black males who were current clients of 52 local barbershops

INTERVENTION DETAILS

Uncontrolled hypertension is a significant problem among non-Hispanic Black men. Barbers in Black barbershops encourage meetings with specialty-trained pharmacists, who are certified as hypertension clinicians. In this study, non-Hispanic Black men with high systolic blood pressure (SBP) levels, defined as readings higher than 140 mmHg on two different screening days, were identified at 52 local, Black-owned barbershops. This study does not include women and those receiving dialysis chemotherapy.

In total there were 319 participants in a cluster-randomized trial where pharmacists prescribed drug therapy under a collaborative practice agreement with the participants' doctors.

In the intervention group, barbers encourage pharmacist follow-up and measure SBP. Pharmacists meet regularly with the participants and counsel them on guideline driven antihypertensive therapies. In the control group, barbers discuss SBP and lifestyle modifications before encouraging participants to seek professional advice.

OUTCOMES

After six months, average SBP decreased by 27 mmHg in the intervention group and 9.3mmHg in the control group. 63.6% of those in the intervention group achieved goal blood pressure vs. 11.7% of those in the control group. Health promotion by barbers results in larger blood-pressure reduction when coupled with medication management in barbershops by specialty-trained pharmacists. Results remain consistent after 12 months, and scaling similar programs would be cost-effective, according to researchers at Columbia University.

RESOURCES

Freakonomics, M.D. "Podcast Episode 6: Are Barbershops the Cutting Edge of Healthcare Delivery?" September 9, 2021. Accessed October 5, 2021.

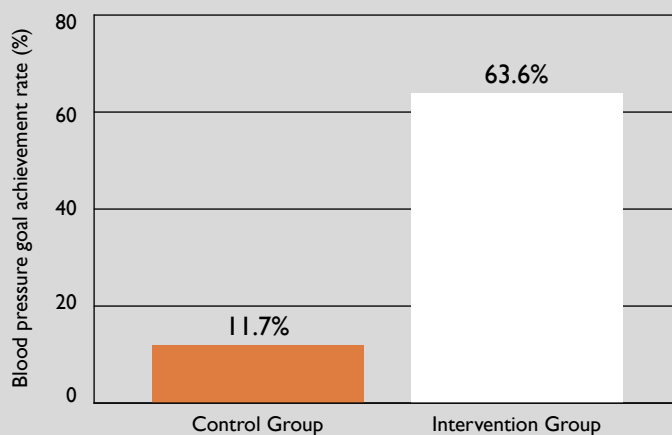
Kazi DS, Wei PC, Penko J, et al. Scaling Up Pharmacist-Led Blood Pressure Control Programs in Black Barbershops: Projected Population Health Impact and Value. *Circulation*. 2021;143(24):2406-2408. doi:10.1161/CIRCULATIONAHA.120.051782

VCU Center for Pharmacy Practice Innovation. "Seminar: A Cluster-Randomized Trial of Blood Pressure Reduction in Black Barbershops." YouTube. March 7, 2020. Accessed October 5, 2021.

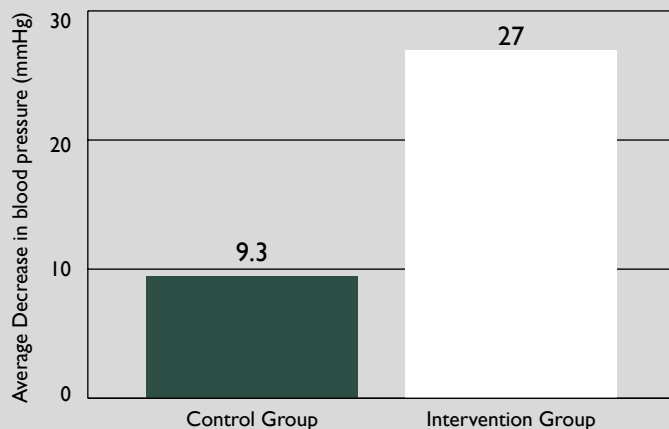
Victor RG, Blyler CA, Li N, et al. Sustainability of Blood Pressure Reduction in Black Barbershops. *Circulation*. 2019;139(1):10-19. doi:10.1161/CIRCULATIONAHA.118.038165

Victor RG, Lynch K, Li N, et al. A Cluster-Randomized Trial of Blood-Pressure Reduction in Black Barbershops. *N Engl J Med*. 2018;378(14):1291-1301. doi:10.1056/NEJMoa1717250

% of Patients who Achieved Goal Blood Pressure



Average Decrease in Blood Pressure



Pharmacist Support to Increase Medication Access in a Faith-Based Clinic

Faith Family Medical Center, Lipscomb University College of Pharmacy

Keywords: Adherence, health literacy, medication cost, patient assistance programs



TYPE OF SERVICE

Screening, Referral, Intervention

BRIEF DESCRIPTION

In a primary care clinic for uninsured or under-insured patients, a pharmacist helps increase patient access to medication through discount pharmacies, samples, coupons, therapeutic medication switching and patient assistance programs.

KEY TAKEAWAY

Over 12 months, this pharmacist-led initiative resulted in more than 450 patients receiving life-savings expensive medications, estimated to cost \$2.8 million, from national patient assistance programs.



SDOH AREAS ADDRESSED

Cost of Medications
Cultural or Literacy Barriers
Screening for Unmet Needs



SETTING

Primary care clinic

LOCATION

Nashville, TN

SCALE

Local



TARGETED POPULATION

Under-insured and uninsured working adults

INTERVENTION DETAILS

Faith Family Medical Center is a faith-based organization whose goal is to provide uninsured or under-insured community members with affordable primary medical care. The center aims to improve health outcomes by enabling individuals to seek medical care before disease advancement. The organization also provides wellness and health education services and resources to community members.

Within Faith Family Medical Center, there is a pharmacist-led initiative to help patients in need access expensive prescription medications. In addition to providing resources, such as coupons and samples, the pharmacist identifies national patient assistance programs, helps patients address complex medication assistance eligibility requirements and completes the applications, responds to information requests, tracks application status and orders medications. The pharmacist plays a crucial role in assisting patients, particularly those with less educational attainment and limited health literacy, in navigating national patient assistance programs administered by pharmaceutical companies.

Additionally, the pharmacist assists patients with ordering refills early, as there are longer lead times to receive medications than from a community pharmacy. One tool for success for this initiative is pharmacists' access to a fax machine as this is the most streamlined method for communicating with some patient assistance programs.

OUTCOMES

This initiative has led to more than 450 patients receiving life-saving expensive medications, estimated to cost \$2.8 million, from national patient assistance programs. Without the initiative, patients would not have been able to afford the medications, or they would have had to forego basics of daily living, such as food and shelter. Participating patients reported better health outcomes, better quality of life and a sense of personal dignity.

The intervention demonstrates how pharmacists can leverage compassionate understanding of patients' SDOH challenges and an understanding of health care navigational challenges like patient assistance programs to improve health status and outcomes.

RESOURCES

Information about this intervention was obtained through correspondence between PQA, Faith Family Medical Center and Lipscomb University College of Pharmacy. For more information about Lipscomb University College of Pharmacy, visit: www.lipscomb.edu/pharmacy and for more information about Faith Family Medical Center, visit: faithmedical.org.

This initiative has led to more than
**450 patients receiving life-saving
expensive medications,**
estimated to cost \$2.8 million,
from national patient assistance programs.

Pharmacy and Community-Based Organization Collaboration to Address SDOH

Community-based organizations (CBOs), community pharmacies, Pharmacy Society of Wisconsin

Keywords: Adherence, care coordination, community-based organizations, grant, medication management, ongoing study



TYPE OF SERVICE

Screening, Referral

BRIEF DESCRIPTION

This initiative promotes collaboration between community pharmacies and CBOs to develop communication tools that address SDOH barriers to medication access and adherence.

KEY TAKEAWAY

Community pharmacies and CBOs will collaborate to develop a best practice model for the Flip the Pharmacy SDOH Change Package.



SDOH AREAS ADDRESSED

Cultural or Literacy Barriers
Screening for Unmet Needs

SETTING

Community pharmacy



LOCATION

Madison, WI

SCALE

Local



TARGETED POPULATION

Community pharmacy patients with medication access barriers

INTERVENTION DETAILS

The Pharmacy Society of Wisconsin supports partnerships between community pharmacies and CBOs to address health literacy and other SDOH barriers related to medication access and adherence.

Initiative Objectives

Establish collaboration between CBOs and community pharmacies with vulnerable patient populations. The collaboration's goal is to address SDOH and communication barriers to medication access and adherence.



Create a standardized communication tool to be used by CBOs and pharmacists. This tool will screen for SDOH factors, support care coordination and promote utilization of medication therapy management services.



Build a best practice model or plan for CBOs and pharmacies that will be included in the Flip the Pharmacy Behavioral Health/SDOH Change Package, similar to previously created Diabetes/SDOH Change Packages.

OUTCOMES

This study is ongoing.

RESOURCES

Community Pharmacy Foundation. "Facilitating Pharmacist-Community-based Organization Collaboration to Improve Medication Management by Addressing Social Determinants of Health." 2021. Accessed November 15, 2021.

Flip the Pharmacy. "What is a Change Package?" September 2021. Accessed November 17, 2021.

Pharmacy Screening for Unmet Social Needs

Towncrest Pharmacy

Keywords: Medication complexity, motivational interview



TYPE OF SERVICE

Screening, Referral, Intervention

BRIEF DESCRIPTION

Towncrest Pharmacy in Johnson County, Iowa, incorporated an SDOH screening tool into their comprehensive medication review (CMR) workflow. The screening is an 8-question verbal survey that a pharmacist or trained pharmacy technician can complete. Pharmacists map community resources to each question, so referrals are made based on the results.



KEY TAKEAWAY

Pharmacists or trained pharmacy technicians screen patients for SDOH factors. Staff identified the two primary factors as lack of transportation and cost of medications. One specific intervention was to decrease a patient's monthly prescription cost from \$100 to \$5.



SDOH AREAS ADDRESSED

Cost of Medications
Cultural or Literacy Barriers
Decent, Safe and Affordable Housing
Food Security
Screening for Unmet Needs
Social Isolation
Transportation

SETTING

Community pharmacy

LOCATION

Iowa



SCALE

Local

TARGETED POPULATION

High-risk patients based on a medication complexity risk score

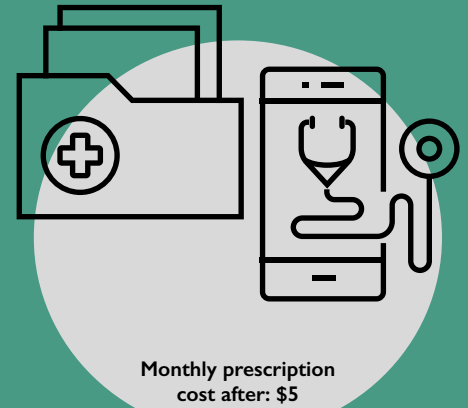
Patient Jane Doe couldn't afford medications, so she quit taking three of them



Jane Doe goes to Towncrest Pharmacy and receives SDOH screening



Pharmacist works with Jane's prescriber to find affordable alternative therapies



INTERVENTION DETAILS

Each CMR incorporates an 8-question verbal screening tool which is administered in approximately 5 minutes. A pharmacist or pharmacy technician can complete it. Pharmacists map each of the questions to community resources in collaboration with the county social services department. Referrals are made based on the results, both for medication access and general medical access issues.

Pharmacists are given additional training in motivational interviewing and ongoing education to adequately field responses from patients, especially regarding more challenging social issues such as abuse or substance use that may arise from the screening.

OUTCOMES

Towncrest identified that the two primary SDOH factors in their patient population were lack of reliable transportation and medication cost. While the pharmacy has a delivery service, they recognize the patient may have issues accessing other care, thus referring them to a county mobility coordinator to address transportation needs further.

For medication cost, the pharmacy has identified several key programs for patients, both at the county and state level, along with benefits investigation through a patient's insurance plan.

One participating pharmacist provided an example, where the screening identified a high-risk, complex patient with mental health issues. The patient could not afford some of her medications and had stopped taking three medications altogether due to a pharmacy bill of several hundred dollars. After discovering this, the pharmacist identified alternative medications with better coverage. The pharmacist recommended the medication changes to the prescriber, and recommended deprescribing two medications, with which the prescriber agreed. The patient's monthly pharmacy cost went from \$100 to \$5.

RESOURCES

Center for Health Care Strategies. "Building the Business Case and Value-Based Payment Models for Enhanced Medication Management." March 1, 2019. Accessed October 5, 2021.

Yard, R. "Screening for Unmet Social Needs: A Conversation with a Community Pharmacist." Center for Health Care Strategies. May 7, 2019. Accessed October 5, 2021.

Yard, R. "Towncrest Pharmacy: Social Determinants of Health Screening survey." Center for Health Care Strategies. May 7, 2019. Accessed October 5, 2021.

SDOH Impact on Statin Adherence

Balls Food Stores – Price Chopper Pharmacy

Keywords: Adherence, completed study, statins



TYPE OF SERVICE

Screening

BRIEF DESCRIPTION

This study evaluated the relationship between SDOH factors and statin medication adherence.

KEY TAKEAWAY

100% of patients with low statin adherence reported at least one SDOH factor, followed by 76% and 42% in the acceptable and high adherence groups, respectively. Patients most often reported lack of employment, financial difficulties, and food insecurity.



SDOH AREAS ADDRESSED

Cost of Medications
Cultural or Literacy Barriers
Decent, Safe and Affordable Housing
Food Security
Screening for Unmet Needs
Social Isolation
Transportation



SETTING

Community pharmacy

LOCATION

Jackson County, MO

SCALE

Local



TARGETED POPULATION

Adult patients with two prescription fills on any statin medication in the previous six months

Childcare Education Housing Personal Safety Employment Food Transportation Utilities Finances

INTERVENTION DETAILS

From February 1, 2021, to March 31, 2021, this study conducted anonymous surveys at three Balls Food Stores in Jackson County, Missouri, a medically underserved area. The aim was to identify factors that impact a patient’s medication adherence and guide individualized medication use support.

This study utilized an adaptation of the SDOH survey from the “EveryONE” project by the American Academy of Family Physicians, which assesses housing, food, transportation, utilities, childcare, employment, education, finances and personal safety. Following the assessment of each SDOH factor, the patient identified if this specific SDOH factor affected their medication adherence. These surveys were administered on electronic tablets at the pharmacy with a randomized drawing incentive for those who participated.

Statin medication possession ratio was utilized to define low (0 – 0.79), acceptable (0.8 – 0.99) and high (≥ 1) adherence groups. Once placed in an adherence group, a message flags each patient’s profile alerting pharmacy staff to offer the patient a survey at the point of sale.

OUTCOMES

Of the 1,019 individuals eligible for the SDOH survey, 67 completed it, a 6.5% response rate. SDOH barriers were indicated 124 times among those who completed the survey. Those with low adherence to statin medications identified that SDOH needs more often affect their ability to take medications than other patients.

Adherence Group	Patients completing survey (n)	Positive responses indicating an SDOH factor (n)	% Reporting at least 1 SDOH factor	% Reporting at least 1 SDOH factor adjusted*
Low	12	22	100	75
Acceptable	41	78	76	44
High	14	24	42	21

*Survey questions about prescription delivery and employment were excluded.

Lack of employment, financial difficulties and food insecurity resulted in the most positive responses indicating an SDOH factor. Financial difficulties, food insecurity and housing instability had the greatest self-reported effect on medication adherence.

RESOURCES

- American Academy of Family Physicians. “Social Needs Screening Tool.” 2018. Accessed October 22, 2021.
- Devereux, D. “Role of Social Determinants of Health in Statin Adherence within Community Pharmacy.” APhA Foundation Incentive Grant 2021. Accessed October 19, 2021.
- Devereux, D. “The Role of Social Determinants of Health in Adherence of HMG-COA Reductase Inhibitors in the Community Pharmacy Setting.” Midwest Pharmacy Residents Conference Abstracts. Page 22. May 12, 2021. Accessed October 19, 2021.

SDOH Screening within Medication Therapy Management Services

Humana, OutcomesMTM

Keywords: Adherence, chronic conditions, education, employment status, health plan tool



TYPE OF SERVICE

Screening

BRIEF DESCRIPTION

OutcomesMTM and Humana implemented an SDOH screening tool in community pharmacies across the United States. This screening tool includes nine questions to assess a patient's overall needs.

KEY TAKEAWAY

Approximately 9,800 patients received SDOH screenings over six weeks. The most commonly reported SDOH factors were social isolation, food insecurity and transportation barriers. Patients who completed these screenings showed an average \$1,500 in decreased medical spending.



SDOH AREAS ADDRESSED

Decent, Safe and Affordable Housing
Food Security
Screening for Unmet Needs
Social Isolation
Transportation



SETTING

Community pharmacy

LOCATION

United States

SCALE

National



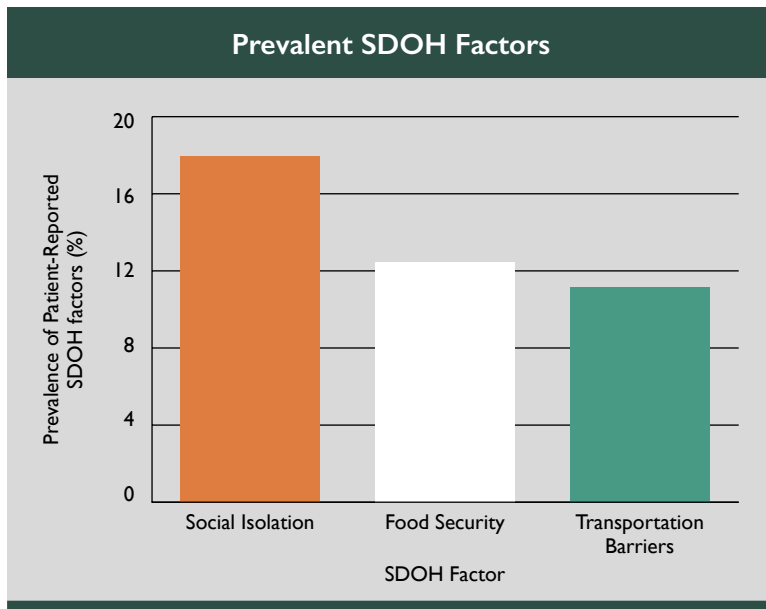
TARGETED POPULATION

Humana Medicare Advantage Prescription Drug (MAPD) plan members

INTERVENTION DETAILS

Humana MAPD members identified as non-adherent to chronic medications from November 15 to December 31, 2019, were screened for SDOH factors both face-to-face or via telehealth modalities by pharmacists. These chronic conditions included atrial fibrillation, chronic obstructive pulmonary disease (COPD), depression, diabetes, hyperlipidemia, hypertension and osteoporosis. Final analysis included individuals who remained enrolled in Humana's MAPD contract and have a chronic condition as part of a two-month post-study period. Pharmacists recorded interactions in OutcomesMTM. The OutcomesMTM platform tracked survey responses and shared information from the pharmacy with health plans.

Pharmacists implemented a nine-question screening tool in over 2,100 pharmacies. This screening identifies patients who need interventions or referrals with the ability to access an embedded tool from Humana directly. This tool is searchable by zip code to identify local resources available to address their needs and refers patients with immediate needs to resources such as Aunt Bertha or the 211 Helpline.



OUTCOMES

Between November 15 and December 31, 2019, pharmacists completed over 17,000 screenings.

The most prevalent SDOH factor reported by patients was social isolation, with 18% of patients reporting this over the past 12 months. Furthermore, 12.5% reported issues with food security and 11.2% reported transportation barriers. COPD and depression were both associated with a higher occurrence of SDOH factors than other patient demographics.

SDOH screening in patients with depression or COPD was associated with a statistically significant increase in medication adherence, defined as a proportion of days covered greater than or equal to 80%. SDOH screening in patients with hyperlipidemia and hypertension was associated with a statistically significant decrease in medication adherence.

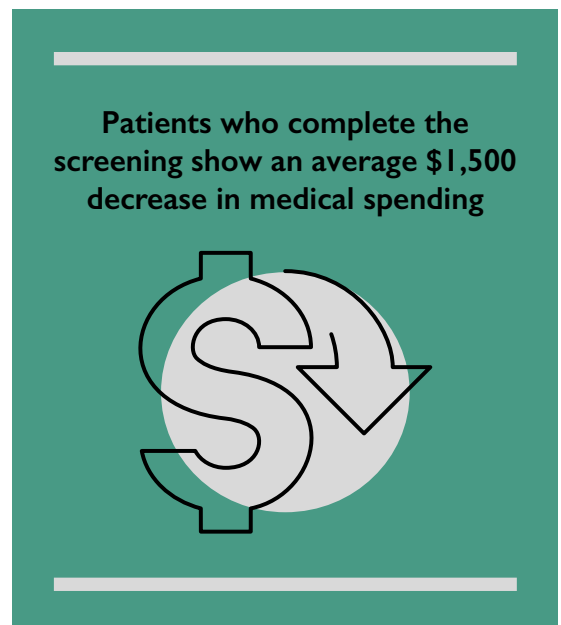
Patients who complete the screening show an average \$1,500 decrease in medical spending, which is statistically significant. There is also an average increase of \$500 per member in the pharmacy spend; however, researchers acknowledged that increased adherence leads to increased pharmacy spending.

Pharmacist feedback regarding implementing an SDOH survey screening tool highlights the need to adjust the survey questions for specific patient populations. For example, asking Medicare patients about school or job training was often not relevant.

RESOURCES

- Aunt Bertha website. Accessed November 3, 2021.
- Helpline Center website. Accessed November 3, 2021.
- Hippensteele, A. "Pharmacists' Role in Tackling Social Determinants of Health." Pharmacy Times. May 18, 2020. Accessed October 22, 2021.
- Ientile, G. "Pharmacists Play Valuable Role in Addressing Social Determinants of Health." Drug Topics. June 11, 2020. Accessed October 22, 2021.
- PQA Annual Meeting 2020 Presentation. "Tackling Social Determinants of Health by Leveraging Community Pharmacies in a National, Scalable Model." May 13, 2020. Accessed October 22, 2021.

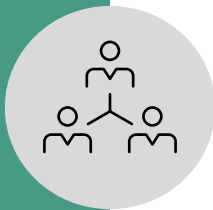
In addition to the resources above, information about this intervention was obtained through correspondence between PQA and Cardinal Health/OutcomesMTM. For more information about Cardinal Health/OutcomesMTM, visit: outcomesmtm.com.



SDOH Specialist Model in New York Community Pharmacies

Community Pharmacy Enhanced Services Network New York (CPESN NY), Independent Practice Association, University of Buffalo

Keywords: Community based organization (CBO), ongoing study, SDOH specialist, training



TYPE OF SERVICE

Screening, Referral

BRIEF DESCRIPTION

SDOH specialists employed by pharmacies serve as a liaison to an Independent Practice Association (IPA), connecting patients to resources to address SDOH factors.

KEY TAKEAWAY

From October to December 2020, IPA and community pharmacies collaborated, resulting in a 23% acceptance rate of patient referrals for community-based social services.



SDOH AREAS ADDRESSED

Cultural or Literacy Barriers
Decent, Safe and Affordable Housing
Food Security
Screening for Unmet Needs
Transportation

SETTING

Community pharmacy



LOCATION

Albany, NY

SCALE

State



TARGETED POPULATION

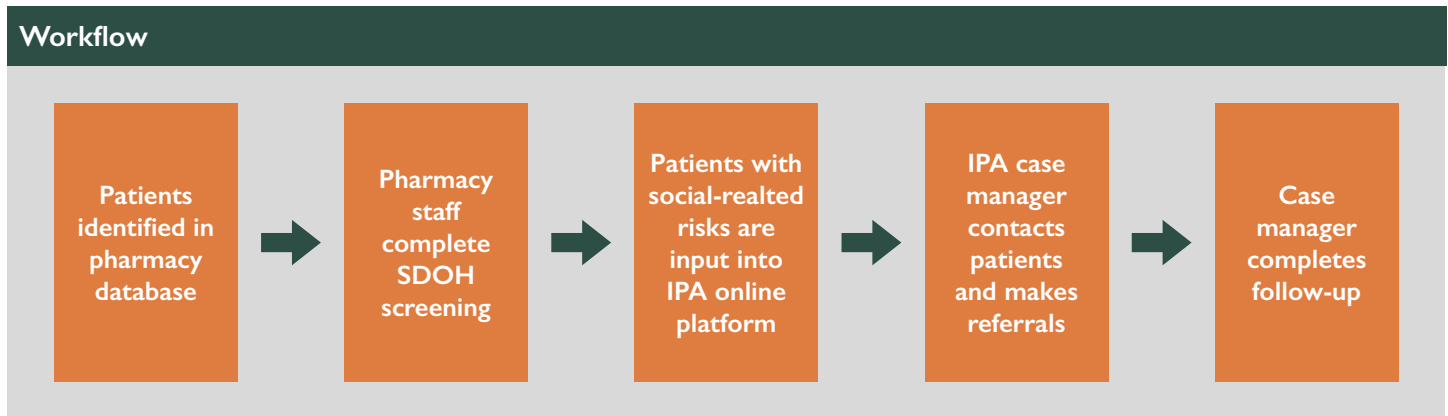
Patients who identify SDOH needs via prompting questions

INTERVENTION DETAILS

This program was initiated in 2020 in New York to establish a working connection between eight independently owned CPESN NY pharmacies and an Independent Practice Association (IPA), a regional organization that provides community-based social services.

Pharmacy technicians and delivery drivers serve as the SDOH specialist and receive training via a National Community Pharmacists Association module. SDOH specialists liaise with the IPA and can lead the SDOH program, educate other staff members on identifying and screening patients, assess screenings for intervention opportunities, implement patient-specific plans, refer patients to non-pharmacy resources and follow up with patients.

Pharmacies make referrals to an IPA via the IPA's technology platform, using information from the pharmacy database, asking prompting questions, which can trigger a more in-depth assessment to better understand specific needs via an SDOH screening tool. In this model, the IPA is responsible for identifying patient-specific community resources, connecting patients to those resources and following up with patients.



OUTCOMES

In preliminary data collected between October and December 2020, pharmacists made 48 total referrals, and 11 patients accepted the referrals. The most common referrals were for transportation and food insecurity. This study is ongoing. The University of Buffalo is a project collaborator seeking to develop a reimbursement model and toolkit for addressing SDOH needs in pharmacies.

RESOURCES

Cunningham, S. "Quality Forum Review: Implementing Sustainable SDOH Programs in Community Pharmacies." PQA Blog. June 15, 2021. Accessed October 26, 2021.

Foster AA, Daly CJ, Logan T, et al. Addressing social determinants of health in community pharmacy: Innovative opportunities and practice models. *J Am Pharm Assoc* (2003). 2021;61(5):e48-e54. doi:10.1016/j.japh.2021.04.022

PQA Quality Forum Video. "Implementation of Sustainable SDOH Programs in Community Pharmacies." YouTube. April 22, 2021. Accessed October 26, 2021.

Utilizing Community Health Workers in Pharmacies to Address SDOH in Missouri

Community Pharmacy Enhanced Services Network Missouri (CPESN MO), Local community organizations, Missouri Department of Health

Keywords: Community health workers, health department, ongoing study, training

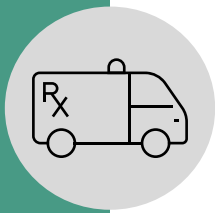


TYPE OF SERVICE

Screening, Referral

BRIEF DESCRIPTION

CPESN MO pharmacies partnered with local community organizations and Missouri's Department of Health to create a bidirectional referral program. Pharmacy staff completes an initial SDOH screening while delivering prescriptions. Community health workers (CHW) then provide SDOH support.



KEY TAKEAWAY

In 2019, pharmacy delivery drivers completed 1,400 SDOH screenings and CHWs made 200 referrals. Patients saved more than \$87,000 in out-of-pocket annual prescription costs.

SDOH AREAS ADDRESSED

Cultural or Literacy Barriers
Decent, Safe and Affordable Housing
Food Security
Screening for Unmet Needs
Transportation



SETTING

Community pharmacy

LOCATION

Charleston, MO

SCALE

Local



TARGETED POPULATION

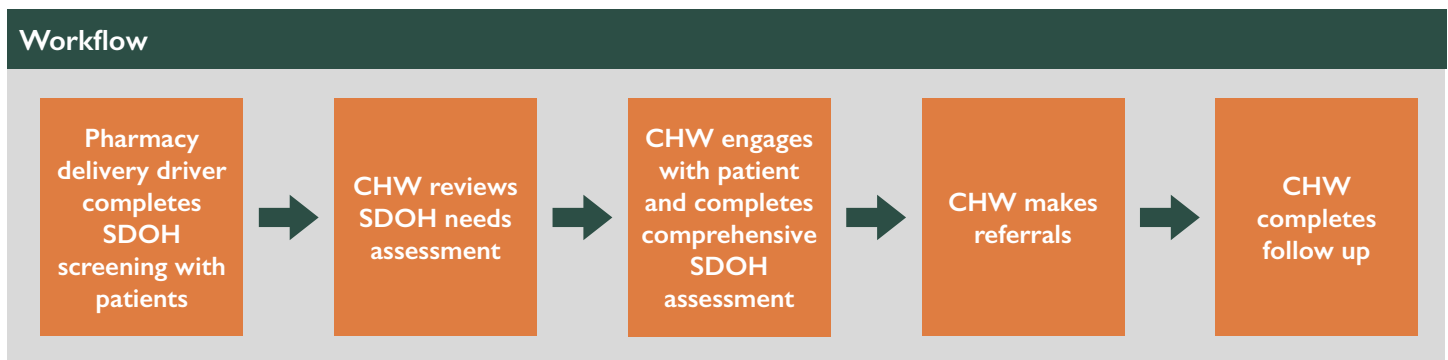
Individuals who utilize the pharmacy's prescription delivery service

INTERVENTION DETAILS

In 2018, CPESN MO pharmacies launched a bidirectional referral program between pharmacies, local community organizations and the Missouri Department of Health. Additionally, CPESN MO pharmacies created a resource book outlining local resources that address SDOH.

All pharmacy staff completed in-house and National Community Pharmacist Association training modules. Interested pharmacy technicians completed additional state-mandated CHW training. In these pharmacies, the CHW-trained pharmacy technicians lead the SDOH program and can also provide service coordination, informal counseling, health education and care management.

Pharmacy delivery drivers screen patients via an SDOH needs assessment tool. Then CHWs review the needs assessment, perform more comprehensive SDOH needs assessments, refer patients to services and follow up with patients.



OUTCOMES

In 2019, a pilot study was conducted. CPESN MO pharmacies completed 1,400 SDOH screenings when delivering prescriptions. Additionally, CHWs made 200 referrals. This study estimated an annual savings of more than \$87,000 in out-of-pocket prescription costs.

This study is ongoing.

RESOURCES

- Cunningham, S. "Quality Forum Review: Implementing Sustainable SDOH Programs in Community Pharmacies." PQA Blog. June 15, 2021. Accessed October 26, 2021.
- Foster AA, Daly CJ, Logan T, et al. Addressing social determinants of health in community pharmacy: Innovative opportunities and practice models. *J Am Pharm Assoc* (2003). 2021;61(5):e48-e54. doi:10.1016/j.japh.2021.04.022
- PQA Quality Forum Video. "Implementation of Sustainable SDOH Programs in Community Pharmacies." YouTube. April 22, 2021. Accessed October 26, 2021.
- 2019 Annual MPA Conference & Expo. "Community Health Workers and Community Pharmacies: The Perfect Match." Missouri Pharmacist Association. September 12, 2019. Accessed October 27, 2021.

1,400 SDOH screenings

200 referrals

Estimated annual savings of
\$87,000 in out-of-pocket
prescription costs



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Screening

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SETTING

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Clinic

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Community pharmacy

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Health plan

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Health system

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Various

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Charitable Donation and Distribution of Medicine.....	12

SCALE

Local

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National

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Rural

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State

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PROGRAM OR STUDY STATUS

Completed program or study

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Ongoing program or study

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ADDITIONAL CHARACTERISTICS

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Behavioral health

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Care coordination

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Coaching, education or training

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Collaborative practice agreement

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Community based organization(s) or services

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COVID-19

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Diabetes

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Grant

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Health department or public health

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Hypertension

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Medicare or Medicaid populations

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Medication management

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Statins

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Students

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Telehealth or telepharmacy

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Incorporating SDOH into Telepharmacy Visits	20

ACRONYM LIST

AHC	Accountable Health Communities
AMG	Ascension Medical Group
BCBS	Blue Cross Blue Shield
CBO	Community-based organization
CCL	Community-clinic linkage
CHW	Community health worker
CMM	Comprehensive medication management
CMR	Comprehensive Medication Review
CMS	Centers for Medicare & Medicaid Services
COPD	Chronic obstructive pulmonary disease
CPESN	Community Pharmacy Enhanced Services Network
DOH	Dispensary of Hope
ED	Emergency department
FFS	Fee for service
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems
IHS	Indian Health Service
IPA	Independent Practice Association
MAPD	Medicare Advantage Prescription Drug
MTM	Medication therapy management
MTP	Medication therapy problem
ONU	Ohio Northern University
REACH	Racial and Ethnic Approaches to Community Health
SBP	Systolic blood pressure
SDOH	Social determinants of health
SNOMED	Systemized Nomenclature of Medicine

NEXT STEPS

PQA, the Pharmacy Quality Alliance, is a national quality organization dedicated to improving medication safety, adherence and appropriate use.

Give us Your Feedback

PQA welcomes your feedback on the format, impact and utilization of this guide. Please email all feedback to Education@PQAalliance.org.

Provide an Update

Please email Education@PQAalliance.org if you have updated information on any initiative that is included in this resource guide.

Inclusion in Future Issues

If you are working on SDOH initiative that PQA can consider for inclusion, please fill out this form.

Stay Connected



[@PQAAlliance](https://twitter.com/PQAAlliance)



[Pharmacy Quality Alliance](https://www.linkedin.com/company/pharmacy-quality-alliance/)

Access This Guide

The PQA Social Determinants of Health Resource Guide was designed to be widely used by the public in many different settings. Download and share this guide via Issuu or as a digital download.

The information included in this guide was obtained from publicly available sources, published literature and in some cases through submission of intervention details directly to PQA and was current at the time it was gathered.



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