

Cultural Competency, Language Access, and Pharmacy Practice – A Proposal

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[excerpt]

Principal Objectives

This project is intended to produce information about pharmacy models and practices to reduce racial, ethnic, cultural, economic, and linguistic disparities in care, avoid errors in the use of prescription and over-the-counter pharmaceuticals, and enhance the efficacy of pharmacy in improving health status of immigrant, refugee, and other limited-English-proficient patient populations. The discovered best models and practices will guide the development and assessment of more effective and cost effective pharmacy services to large numbers of low-income, ethnic minority, linguistic minority, and immigrant and refugee patient populations.

We propose to conduct an analysis of the best culturally/linguistically competent pharmacy models within the contexts of a rapidly changing pharmacy profession, industry, and institutional health care system, growing immigrant and refugee populations, and growing numbers of ethnic, racial, and linguistic minorities relying on publicly-supported health care.

Background

There exists a very large patient population, which includes a substantial component of non-Caucasian patients, members of which often have very limited ability to understand or be understood in the health care setting, due to the combined effects of limited education, limited power in the health care setting, high stress, underlying illness, and alternative concepts, experiences, and expectations of health care.

For many immigrant and refugee populations, this inability is exacerbated by limited or non-existent English-language competency, thus limiting their understanding and use of prescribed medications. Many lack the ability to read in English or in their native language, making it difficult to understand and comply with written instructions. It is also common to have no direct 'one-to-one' language equivalencies from 'medical' English to their own colloquial language(s). Many also rely on medications and remedies from within their own cultures and countries of origin. Finally, many have been socialized, in their home countries, to entirely different paths to seeking, obtaining, and using medications developed by the international pharmaceutical industry and/or indigenous formularies and sources. Bringing these expectations, understandings, and behaviors to the American system of health care results often in great gaps between providers and their neediest and most at-risk patients. These factors combine with issues of access to pharmaceuticals and associated cost barriers (Regenstein, et al.,2000) to

result in significant disparities in the ability of minorities to benefit equitably from these services and substances.

In overcoming the barriers to quality health care to these populations, the need for clear communication in informing and counseling the patient is critical. Pharmacy is a critical linchpin in the provision of care to these populations in dispensing, educating, monitoring, and management. It is critical as it is often the first and last points of care. The pharmacist may be the only healthcare provider who is relatively accessible, and/or will take time to talk to the patient and pharmacy may be the only point of access for some portion of the population that for various reasons will not seek care from a clinic or physician or preferentially seeks care from a pharmacist. And the pharmacist may be the final but most critical step in the treatment process as patients seek to understand, fill, and follow their prescriptions; all preceding medical steps may be futile without it.

Pharmacies often have limited or no access to bilingual staff or qualified interpreters to bridge the communications gap through language and graphics. The pharmacists consequently cannot obtain sufficient feedback to assure themselves that patients do in fact understand instructions and their consequences. Thus, when patients move from a multi-lingual health care setting (such as a hospital, community health center, migrant health center) to the pharmacy, they often lose language and cultural supports just as the most critical and practical aspects of their treatment are about to take place.

These factors combine to increase the likelihood of miscommunications between the patient and pharmaceutical care provider, resulting in medical noncompliance, error, and reduced health status.

Previous studies have noted common ways in which medication instructions become garbled and/or mingled with conflicting values and beliefs. Some examples: Patients stop their course of care prematurely because of a misperception that it is not working, or because the immediate symptoms have been alleviated. Patients purchase only as much medication as they can afford, rather than the quantity which would be efficacious. Patients use medications based on cost considerations more than efficacy. Patients make over-literal interpretations of instructions, such as ‘take one pill three times daily’, by taking one tablet and breaking it into three pieces that they consume over the course of a day.

“One of the things that’s really been disturbing in the area of cross cultural competency in pharmacy is the extra miles that pharmacists really have to go in order to actually make sure that their patients really do understand what the drug is, how long they’re supposed to take it, how many times you’re supposed to take it, if they’re supposed to take it beyond the course of the symptoms disappearing, and all the rest of that. And language and culture are very powerful barriers to compliance with the pharmaceutical regimen.” (from a community health center pharmacist)

These problems are a major extension of the more general issues of communications and compliance in medicine and pharmacy with all populations. These problems pose serious

issues for resulting health status and professional practice, medical compliance, medical risk, medical efficacy, legal liability, error, disparity, quality of care, and compliance insurance coverage.

However, these problems are themselves embedded in a larger set of conditions that must be understood if progress is to be made. Pharmaceuticals are becoming increasingly important in the prevention of disease and the care of chronic illness; consequently, their proportion of the overall health care cost is rising rapidly and is subject to increased scrutiny and control in the managed care environment. There are other concurrent changes:

- The direct advertising of pharmaceuticals to the public;
- The increased number of over-the-counter medications;
- The education and demographics of pharmacists (particularly in clinical pharmacy);
- The organizational structure and purposes, economics (e.g., reimbursement mechanisms and rates), and automation of clinic/hospital-based, HMO-based, and retail pharmacies and functions, (e.g., unit dose drug dispensing);
- The roles, functions, regulated scope of practice, and job futures of pharmacists as health care providers (e.g., first point of access to health care, immunization and immunization outreach, diabetes outreach, emergency contraception, referral, counseling) compared to those of pharmacy technicians, physicians, and nurses;
- An increased uncertainty about the future of pharmacy as a distinct clinical and consultative profession;
- The growth of on-line sources of pharmaceuticals;
- The changing and increasing insurance coverage for pharmaceuticals;
- The location of pharmacies serving the poor and immigrant communities;
- The automated translation of prescriptions and instructions;
- The multiple opportunities and challenges of pharmaco-genomics;
- And the increasing responsibility of HMOs and safety net providers for the health status of Medicaid managed care and uninsured patients, through the provision of primary preventive health care services.

All of these factors shape the ability of poor and immigrant patients to be participant in their own care and, ultimately, benefit from the publicly-funded health services designed for their care. Advances in services to and outcomes for the poor can be made only if best models are embedded properly in these other systems changes.

[balance of the text and supporting literature of this unfunded proposal available on request]