

The role community pharmacies can play in reducing health inequities

Deloitte Center for Health Solutions

By moving into clinical services and becoming part of comprehensive care teams, community pharmacies can improve access to care and reduce health inequities.



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Recognizing community pharmacies as key resources in improving health equity

The US health care system struggles to reduce health inequities, which translates to poor patient outcomes and an additional \$320 billion in annual health care spending. But there's one potentially powerful ally that is often overlooked and underutilized: the community pharmacy. With their established trust, community footprint, and patient-centric approach, community pharmacies are well-positioned to advance health equity.¹

WHAT IS A COMMUNITY PHARMACY?

A type of pharmacy typically located in a community setting, like a community grocery or drugstore chain, an independently owned small business, or ambulatory settings like clinics or federally qualified health centers.⁴ Nearly 90% of Americans live within five miles of a community pharmacy.⁵ Moreover, there are approximately 28,000 pharmacies located in federally recognized underserved communities.⁶

As Magaly Rodriguez de Bittner, professor at the University of Maryland School of Pharmacy, told us in an interview, “Community pharmacies are deeply integrated into their communities, they have one of the best opportunities to advance the agenda of health, equity, diversity, and inclusion. They are the anchor institution to serve the health needs of that community especially when hospitals are not nearby.” It is important to recognize community pharmacies as valuable partners rather than competitors if we truly seek transformative change.

Community pharmacies already do many things that improve care, access, and outcomes for disadvantaged populations. The pharmacists who work in these settings identify medications that patients can afford, provide counseling about over-the-counter (OTC) options, prescribe birth control, and educate about age- and gender-appropriate preventive screenings.² During the COVID-19 pandemic, community pharmacies delivered more than 300 million doses of the COVID-19 vaccine with approximately 70% of vaccinating pharmacies located in areas with moderate-to-high social vulnerability (see figure).³

Figure

Empowering communities: the vital role of community pharmacies in accessible and equitable health care

The COVID-19 pandemic demonstrated the value of community pharmacies in reducing health disparities by providing convenient and accessible care, and fundamentally changed the way Americans view their local pharmacy.

Throughout the COVID-19 pandemic, community pharmacists delivered:

300M+
COVID-19 vaccines

42M+
COVID-19 tests



of vaccinating pharmacies are in areas with moderate to high social vulnerability

Source: Centers for Disease Control and Prevention, "The federal retail pharmacy program for COVID-19 vaccination," July 7, 2023; Loren Bonner, "Quantifying the 'heroic' work of pharmacists during the pandemic," *Pharmacy Today* 29, no. 1 (January 2023): pp. 23–26.

If the status quo continues, pharmacy deserts will likely grow, and health inequities could deepen. By collaborating with community pharmacies as partners, payers and providers can tap into their connection with the community and their expertise in pharmacology, chronic disease management, and patient engagement.

The Deloitte Center for Health Solutions conducted interviews with 37 leaders from community pharmacies, health plans, pharmacy benefit managers, academia, quality organizations, pharmacy associations, and life sciences companies to understand how community pharmacies could make a bigger impact on reducing health inequities and what the industry should do to enable and sustain these efforts. Based on this research, we propose ideas for how community pharmacies, payers, and providers could collaborate to overcome ecosystem challenges.

As we discuss in *The pharmacist of the future*, the practice of pharmacy should move beyond medication dispensing into clinical services, such as chronic condition management, prevention and wellness initiatives, diagnosis and treatment support, and even mental health and aging-in-place services. While some community pharmacies have expanded their business models to provide these services, this is not yet the norm.⁷ By moving into clinical services and becoming part of comprehensive care teams, community pharmacies could improve access to care and reduce health inequities.

Chronic conditions are the leading cause of death and disability in the United States, contributing to 90% of annual health care costs.⁸ Racially and ethnically diverse patients are more likely to be diagnosed with chronic diseases, and face increased morbidity and mortality rates.⁹ The root causes of these disparate health outcomes

include racism and bias, structural flaws in the health care system, and deep inequities within the drivers of health (DOH) or the social, environmental, and economic conditions that impact health.¹⁰ Resources are needed to better understand community-level needs and target interventions that improve chronic disease prevention and care.

In recent years, there has been an increase in the use of health and wellness services provided by community pharmacies. Nearly 80% of consumers see pharmacists as essential members of the health care team¹¹ and 58% prefer to visit their local pharmacies as the first step in seeking nonemergency care.¹² And a recent study by CVS Health found that 61% of consumers would like to get even more health services from their local pharmacy.¹³ Yet 59% of physicians practicing in outpatient settings say they do not use a care team that includes a pharmacist, according to the Deloitte survey findings presented in *Evolving the team-based care model*.

Community pharmacies' contributions to reducing health inequities often go unnoticed, and the current reimbursement structure fails to recognize their value.¹⁴ If the status quo continues, pharmacy deserts will likely grow, and health inequities could deepen. By collaborating with community pharmacies as partners, payers and providers can tap into their connection with the community and their expertise in pharmacology, chronic disease management, and patient engagement.

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Community pharmacies as vital members of the care team

Traditional health care organizations generally struggle to address health inequities and no single sector can do this work alone. It will take an ecosystem of organizations to impact health through innovation and collaboration. The statistics on care management reveal that in 2019 only 4% of individuals who could benefit from chronic care management received those services.¹⁵ Pharmacies can help both payers and providers better engage with consumers. Often, the populations that can benefit the most are the hardest to engage. While pharmacies already do many things that improve health equity, these activities tend to be ad-hoc, uncoordinated, and unreimbursed. If community pharmacies become part of the care team, they can assume greater responsibility for patients. This could be valuable to providers, payers, and patients alike.

In this research, we discuss three areas where community pharmacies could make a large impact on health inequities if they are part of the care team:

- Greater collaboration with the community to address the DOH. Integrating pharmacy technicians trained as community health workers (CHWs) has shown potential in addressing social DOH in several states where such programs have been implemented.

- Expanding preventive services. By adding distance learning to an existing evidence-based diabetes prevention program, community pharmacies improved participant engagement and program completion and ensured program continuity during the pandemic.
- Chronic condition management for high-risk populations. A health insurer reduced racial and ethnic inequities in adherence to cholesterol and diabetes medications by understanding the causes behind inequities and implementing culturally competent pharmacy interventions.

Yet several conditions should be in place for innovations like these to be implemented at scale: *interoperable data infrastructure*, *novel equity-centered payment models and benefit designs*, and *innovative care models*. It's unlikely that any single stakeholder can create these conditions alone. Through collaboration and action from payers, providers, community pharmacies, and technology vendors, health equity can become the central goal of the health care system.





Greater collaboration with the community to address drivers of health

Another opportunity for community pharmacies lies in their ability to empower individuals and families by enhancing health literacy, supporting them in navigating benefits, selecting the insurance plan that meets their needs, and addressing language barriers.

Community pharmacies play an important role in accounting for various social, economic, and environmental needs by helping to ensure the safe and appropriate use of medications. After considering clinical factors such as medical history and drug interactions, they regularly assess patient-specific needs to optimize health outcomes.¹⁶ Dixie Leikach, managing network facilitator at Community Pharmacy Enhanced Services Network of Maryland, explained in an interview, “As pharmacists, we see patients daily and sometimes multiple times a day. We tend to be the person that finds out about certain challenges patients have. Are they having trouble paying for electricity or food? Are they unable to work due to childcare? Pharmacists are the first level of providing information to patients to receive resources they qualify for but may not be aware or know how to qualify for.” This is a great example of how pharmacists can gather information about living conditions, financial constraints, and employment status through active listening and observation. In addition, they routinely help patients navigate prescription benefits and identify cost-effective options.

However, a more systematic approach to addressing the DOH would involve expanding the role of pharmacies to include additional support services. By establishing

partnerships with transportation services, they can help ensure patients have reliable access to medical appointments and essential health care services. Pharmacies can refer to appropriate telehealth options, which can expand access to care for individuals facing mobility or geographical barriers. Pharmacies can offer information on housing resources and support initiatives addressing homelessness. They can provide nutritional counseling and information on food assistance programs, and collaborate with community food banks to address food-related inequities. Another opportunity for community pharmacies lies in their ability to empower individuals and families by enhancing health literacy, supporting them in navigating benefits, selecting the insurance plan that meets their needs, and addressing language barriers.

To screen for and reduce inequities related to the DOH, the Community Pharmacy Enhanced Services Network (CPESN) USA has launched initiatives to integrate community health workers (CHWs) into pharmacies. Pharmacy technicians at several community pharmacies got trained as community health workers to support these efforts (see, “Community pharmacy as a connector to resources”). In a recent 12-week feasibility study at a single pharmacy, CHWs screened 86 individuals and provided interventions or referrals to address social needs for 24% of the screened individuals, with most participants being Medicaid members.¹⁷

COMMUNITY PHARMACY AS A CONNECTOR TO RESOURCES

Addressing social determinants is not new territory for community pharmacies, according to Lindsey Ludwig, executive director at CPESN Iowa. And even though they already do many activities related to health equity, the biggest opportunity in her view is being a resource connector. The CHW program does just that.

She illustrated this point with an anecdote: A patient came in to settle a relatively small bill, but when a pharmacy technician ran his debit card, it was declined due to insufficient funds. The patient was visibly frustrated and embarrassed. The technician talked to the patient and realized that he may not

be receiving all the necessary resources. They then gathered some additional information and passed it on to a community-based organization that assessed the patient's eligibility for disability benefits due to his military service.

By taking the time to "peel through the layers to identify what the patient is actually eligible for," the technician, who is trained in community health work, put the patient on a much better life path. His disability benefits increased from about \$1,000 to more than \$3,000 per month. He no longer needed to go to the food bank every month or visit another organization that was providing him with some

rent assistance. He is self-sustaining and much more confident because he now receives the full benefits he is entitled to.

Certification for pharmacy support professionals in community health work may vary in length (16 or 20 weeks); it involves training in effective patient communication, resource identification and connection, patient education, patient encounter documentation, and referral process supervision including follow-up and monitoring.¹⁸





Expanding preventive services

During the COVID-19 pandemic, payers and providers faced challenges in delivering preventive services to underserved populations. Challenges including access barriers, limited health literacy, socioeconomic factors, mistrust, and resource limitations exacerbated existing inequities.¹⁹ These challenges underscored the importance of community pharmacies' role in targeted outreach, improving health literacy, and ensuring equitable access to preventive care. Community pharmacies can help close gaps in preventive services that traditional health care entities may not be able to. For example, they can reduce medication nonadherence, which is a leading cause of poor hypertension management that disproportionately affects Black patients.²⁰ They could also help prevent the spread of communicable diseases through rapid point-of-care (POC) testing, potentially eliminating the need for individuals who may have transportation barriers to travel to laboratories.

In an interview, Dima M Qato, associate professor at the University of Southern California (USC) Mann School of Pharmacy and Pharmaceutical Sciences and a senior fellow at the USC Leonard D. Schaeffer Center for Health Policy & Economics, explained, "More than 75% percent of COVID-19 vaccines in the country were provided at a community pharmacy. Pharmacies are access points for other types of health services, including immunizations, prescribing contraception, HIV prevention, and [obtaining] buprenorphine and naloxone for opioid use disorder. They are integral not just for

treating conditions but for preventing disease." By offering convenient access to these services, pharmacies have become valuable hubs for preventive care within local communities.²¹

In one innovative care model,²² retail pharmacists work as "health advisors" to provide patients with a convenient place to address specific health care needs, receive select health screenings, navigate benefits, find care providers, and schedule appointments. Since the program launched in 2020, pharmacies have facilitated more than 300,000 patient interactions.²³

Another innovation is the use of point of care (POC) and OTC diagnostic testing. While such testing is not new, the pandemic highlighted the important role of arming community pharmacies with POC and OTC tests to enhance access among underserved populations.²⁴ This is especially important in health care deserts and for populations that may not have a regular primary care provider.

Payers and providers stand to benefit from such collaborations. (See, "Making diabetes prevention programs more accessible," for more information.) One community pharmacy chain we spoke with partnered with a health plan in California to educate and promote to their members screenings for colorectal cancer, known to disproportionately impact Black Americans.²⁵ Members were eligible to access the testing through 600 local pharmacies or receive it directly by mail. Pharmacy staff provided education and reminders to enhance

patient compliance. As a result, 8,000 members were screened and 330 members were identified as needing a colonoscopy.²⁶ Another community pharmacy we spoke with works directly with payers to understand their priority areas and gather lists of high-risk patients that

pharmacies can use to close gaps in care (e.g., immunization consultation, blood pressure reading, colorectal screening). The pharmacy would then document in its clinical documentation tool and submit that data (unique to each payer) back to the payers.

MAKING DIABETES PREVENTION PROGRAMS MORE ACCESSIBLE

Pre-diabetes affects 96 million people in the United States. Without changes in diet and lifestyle, these people are destined to develop type 2 diabetes.²⁷ The CDC has developed an evidence-based diabetes prevention program²⁸ which is a structured, year-long lifestyle change and educational program with a high degree of success: Fifty eight percent of those who participate in and complete the program will not develop diabetes in the next five years.²⁹

Despite its strong track record, there are still underserved areas where people at risk of diabetes have little to no access to the program. Furthermore, some at-risk populations are harder to engage. In 2017, the CDC expanded the program, funding 10 national organizations, including the American Pharmacist Association Foundation.³⁰

Benjamin Bluml, executive director and senior vice president for research and innovation at the

American Pharmacists Association Foundation, described: “[The focus of the program is on] Medicare beneficiaries, African Americans, Asian Americans, Hispanics, American Indians, Alaskans, native Pacific islanders, and people with visual impairments or physical disabilities, and the one I saved for last is simply men. It turns out that getting men to focus on prevention-related activities is extremely difficult for a variety of reasons.”

The program was traditionally delivered in person over the course of a year, with 26 in-person sessions. Under the guidance of a trained lifestyle coach and with the support of a peer group, participants engaged in healthy coping, healthy eating, physical activity, and self-monitoring to reduce the risk of developing type 2 diabetes. However, data shows that patients found it difficult to continue and complete the year-long program. To offset that, the program was modified. In addition to

face-to-face visits, participating pharmacies added distance learning that involved telehealth-supported interactions with the lifestyle coach and the peers, and a digital application that enabled online access to educational resources. This omnichannel approach proved valuable during the pandemic so patients could continue with the program.³¹

Dr. Bluml noted that pharmacy technicians make for effective lifestyle coaches: “While there are around 320,000 practicing pharmacists, the pharmacy technician workforce exceeds 400,000, and thus leveraging their skill set and training them as lifestyle coaches for prevention activities proved to be an economically efficient use of resources. By rallying our technician workforce to be more activated and engaged in prevention-related efforts, pharmacists get more time to focus on the care management side.”



Chronic condition management for high-risk populations

“[We are] at a time when the whole health care industry is saying that we care about reducing health inequities. But candidly, when you look around, there’s not a lot of real action around it.”

—Sachin Jain, CEO, SCAN

Chronic conditions are the leading cause of death and disability in the United States, contributing to 90% of annual health care costs.³² However, the disease burden falls disproportionately on minority populations, revealing unsettling inequities.³³ Let’s take a closer look at diabetes, a condition that affects more than 37 million Americans.³⁴ Compared to non-Hispanic whites, American Indians and Alaska Natives are almost twice as likely (96%) to be diagnosed with diabetes. Non-Hispanic Black adults face a 64% increased likelihood, and individuals of Hispanic ethnicity face a 59% higher risk. The ripple effects of these inequities extend beyond diagnoses. Racially and ethnically diverse populations living with diabetes experience a higher prevalence of debilitating complications, such as foot and toe amputations and kidney disease.

Nearly all respondents identified pharmacist-led chronic care management as the most obvious opportunity to improve health outcomes for disadvantaged patients. (See, “Building a culturally competent pharmacy program to close medication adherence gaps,” for more information.) As medication experts, pharmacists can help ensure appropriate medication use, optimize therapy, and address medication-related issues in complex

patients. Other pharmacist-led care coordination activities, such as patient follow-up, medication reconciliation, and monitoring of treatment plans, can help enhance patient engagement and adherence to therapies, ultimately resulting in better disease management and improved health outcomes.³⁵

Our respondents recommended focusing on common conditions like diabetes, asthma, chronic obstructive pulmonary disease, high blood pressure, or conditions with high risk or prevalence in local communities like human immunodeficiency virus (HIV). By targeting these conditions, pharmacists can have a significant impact on improving health outcomes for more patients.

Another opportunity is to develop care transition programs to support patients during transitions between health care settings, such as hospital to home or hospital to a rehabilitation or skilled nursing facility. These programs can leverage the expertise of community pharmacists to help ensure seamless care coordination and medication management. By actively participating in care transitions, pharmacists can manage polypharmacy, reduce medication errors, improve medication adherence, and enhance patient safety.

BUILDING A CULTURALLY COMPETENT PHARMACY PROGRAM TO CLOSE MEDICATION ADHERENCE GAPS

In 2020, SCAN health plan, a not-for-profit Medicare Advantage plan that serves more than 270,000 people in Arizona, California, and Nevada took a close look at its annual quality scores. Even though SCAN is a high-performing plan with a star rating of 4.5, they saw racial and ethnic inequities in adherence to cholesterol and diabetes medications.³⁶ They made medication adherence a top organizational priority and tied 10% of executives' bonuses to reducing inequities in medication adherence.³⁷

Through ethnographic interviews with both plan members and staffers who work closely with members, they learned why some of their members didn't take their medications as prescribed. A few reasons included being unfamiliar with their prescription benefit, not understanding

why they should take their medications, language difficulties, and lack of transportation. To help address these inequities, SCAN increased medication home delivery and trained its health care navigators on how to engage in culturally sensitive conversations. They went one step further and paired up members with navigators of similar ethnic and cultural backgrounds. It was a collective effort that involved internal and external pharmacists, care navigators, and nurse-practitioners to provide direct member outreach and in-home medication consultations, and behind-the-scenes coordination between SCAN's legal and analytics teams, academic collaborators, and vendors.

After one year, SCAN reduced the racial and ethnic medication adherence gap by 35% and roughly

700 Black and Hispanic members started taking their medications as prescribed. As of 2022, the company spent close to \$1 million on this initiative, dedicating 50 staff members and external vendors to reaching out to members frequently. The program is ongoing, and SCAN has set new goals to improve diabetes control among Hispanic members and flu vaccination rates among Black members.

The future will tell whether SCAN is the exception to the rule or a harbinger of industry innovation. According to SCAN CEO Sachin Jain, "[We are] at a time when the whole health care industry is saying that we care about reducing health inequities. But candidly, when you look around, there's not a lot of real action around it."



Challenges on the path to health equity

Achieving health equity requires developing tailored services that address the unique needs of diverse populations. In a community pharmacy setting, this means shifting from a product-oriented model to an outcomes-focused service model. Today, several challenges stand in the way of implementing such a shift. According to the leaders we interviewed and consistent with the Deloitte Center for Health Solutions' previous research, data infrastructure, payment models and benefit designs, and pharmacy business models are the main ones. The respondents also acknowledged that overcoming these challenges requires commitment and action from all sectors of the industry: pharmacy, payers, providers, regulators, technology developers, and standard setting bodies.

Interoperable data infrastructure

An effective data infrastructure can enable pharmacies to provide tailored services that address health inequities. However, the existing infrastructure is deficient not just in pharmacy but across the entire industry.³⁸ Although progress has been made with clinical data sharing among providers, availability and liquidity of data on health disparities or the DOH is limited.³⁹ Without access to

comprehensive patient data and with limited visibility into health service utilization, pharmacies are left to rely on their own data or operate without a clear understanding of inequities, and are therefore unable to target interventions and address specific health needs.

Today, the most comprehensive source of patient data is probably held by health plans: Their systems contain demographic data, such as age and zip code, and health information like diagnoses, and utilization of medical and pharmacy services. Even still, this data has major gaps: Race and ethnicity information is largely absent, not all health care encounters get captured, clinical information may be limited, and lags can be considerable.⁴⁰ The lack of interoperability with health care providers further exacerbates the problem.

Payment models and benefit designs

Today's benefit designs, reimbursement models, pharmacy network development methodologies, and care models impede progress toward health equity.

Take pharmacy deserts, for example: Nearly one in four US neighborhoods lack convenient access to pharmacies, and hundreds of pharmacies close every year.⁴¹ There

are fewer pharmacies in Black and Hispanic neighborhoods compared to white or diverse neighborhoods.⁴² In those underserved communities, the closest pharmacy is usually an independent pharmacy—and independents are often excluded from narrow networks common today. Even when they are in-network, reimbursement rates are often less than what it costs them to dispense the drug,⁴³ with Medicaid paying the least. Between losing customers and patients because of narrow networks, below-cost dispensing fees, and a disproportionate share of unprofitable Medicaid dispensing, independent community pharmacies can't make enough money to survive as a business.⁴⁴ So they close, explained Dima Qato.

Even when pharmacies diversify away from dispensing, getting paid for clinical services, education, and preventive programs is anything but straightforward. Reimbursement models are different across Medicaid, commercial, Medicare Advantage, and standalone Part D plans, whether they're designed for traditional pharmacy activities like medication therapy management or for innovations like community health services.

With few exceptions, our respondents expressed that granting pharmacists a national provider status would create the right environment for pharmacy transition from dispensing to services, and smooth out

state-by-state variability on what pharmacists and pharmacy technicians can do. This would enable pharmacies to bill for services not only through the pharmacy benefit like they do today but through the medical benefit too. An alternative approach to billing for pharmacy-provided clinical services could resemble billing for pharmacy-administered vaccines.

The innovative health equity initiatives in community pharmacies that we identified through this research rely on grant funding, raising concerns about their long-term financial viability. But to develop new reimbursement approaches with payers, they find themselves in a Catch-22. Payers may be unwilling to invest in health equity programs involving pharmacy until there is sufficient evidence of their effectiveness. However, generating evidence requires implementation or at least piloting of such programs. Collaboration is needed to generate evidence and demonstrate the value of health equity initiatives. Some pharmacy industry groups, such as CPESN, have taken the lead in this regard.⁴⁵

Lastly, the ability to make lasting changes requires that decision makers empathize with the people the decisions affect. Unless individuals who represent the communities being served are part of the decision making at the very top, the programs that come out of the board rooms and



corner offices may not serve the needs of those communities. As one of our respondents shared, “When you see people who are really doing well trying to talk about the health care for those below, I have doubts. I’ll give you an example. I go into a room full of insurance executives. And we start our meeting with an icebreaker: ‘What’s the best first-class flying experience you’ve ever had?’ And I say, ‘I’ve never flown first class.’ They looked at me like I was the strangest person in the world. I can’t imagine that these people would want to solve for health inequities. If they do, they will probably make the decisions that have no relationship to the population or the need.”

Pharmacy business model

Unlike providers and payers, the community pharmacy business model is under threat due to increased competition, overcapacity, and reduced revenue.⁴⁶ Recent closures of free-standing and in-store pharmacies lend support to this view.⁴⁷ And more pharmacy closures will lead to pharmacy deserts.⁴⁸

While threats to the business model can create the urgency to innovate, they also limit the resources pharmacies can allocate toward new service development. As discussed in the *Pharmacist of the future* report, investments should be made in workflow and staffing, revenue models, technology systems, and change management.

In addition, community pharmacies face an image problem. Many in the industry do not see pharmacists as providers capable of delivering clinical services.⁴⁹ The opposition from the American Medical Association to the FDA’s decision to authorize pharmacists to prescribe Paxlovid is just one example.⁵⁰ This perception can undermine the recognition and utilization of pharmacies in health equity efforts. Indeed, if pharmacies are viewed solely as a medication dispensing function, there is little urgency to act since pharmacy is not a significant contributor to overall health care spending.⁵¹

Health equity requires collective action



Making progress on health equity requires payers, providers, and community pharmacies to commit to and collectively align and act on changes to *data infrastructure*, *novel payment models and benefit designs*, and *innovative care models*. Without this collective action, things will largely remain the same: The industry will see more small, nonscaled initiatives being carried out, ongoing duplication of effort, and poor access leaving consumers to their own devices to navigate the fragmented system.

We lay out three scenarios of how the future may unfold:

- The *status quo* where the pharmacy remains a dispensing function struggling to demonstrate value and to contribute to health equity.
- Under the *medium case scenario*, we anticipate increased commitment to health equity as a goal, encouraged by regulatory or reporting requirements.

Health plans would publicly report health inequities for all lines of business, including by race and ethnicity. Initially, they would use imputation methods to estimate race and ethnic inequities; over time, imputed estimates get replaced with actual data that community pharmacies help gather. Better data should lead to improved understanding of health inequities, which in turn could support development of insurance products and networks that do not disadvantage retail and independents. An evolution of methodologies for pharmacy network adequacy and for pharmacy reimbursement could slow down pharmacy desert formation.

The reimbursement for inpharmacy clinical services, however, remains unaddressed in this scenario limiting opportunities to deal with health inequities in a targeted fashion beyond medication management.

While we expect improved data exchange between payers and pharmacies, clinical data sharing with providers is not yet in place, and even within

the confines of the same organization, visibility into clinical data inside the EHR remains role-dependent.⁵² This would limit the ability to develop care teams that seamlessly incorporate community pharmacy.

- Under the *best-case scenario*, health equity becomes the central goal of the health care system and a core feature of health insurance products. All industry stakeholders would regularly audit their products, systems, processes, and care models for sources of bias and inequities, and all new products would be developed with a health equity lens.

We anticipate greater interoperability and the real-time exchange of information among payers,

providers, and pharmacies. We also expect all stakeholders (including pharmacies and providers) would share and contribute clinical, demographic, and DOH information in real time. Real-time data sharing would serve as fertile ground for new care models, in which the lines between community pharmacy and in-house pharmacy no longer exist. We envision reimbursement mechanisms for pharmacy-delivered clinical services, health education, disease prevention, and care management that use intuitive patient attribution methodologies. Enhanced interoperability, real-time exchange of information, and reimbursement for clinical services could also foster the identification, recruitment, and retention of diverse and often excluded populations in clinical research.



The commitment to addressing health equity

The health care industry has a choice to make: maintain the status quo or pursue progress toward health equity. The pandemic emphasized the important role that community pharmacies can play in helping socially vulnerable populations.

Interview participants were cautiously optimistic that as a society we can make progress toward achieving equity, and community pharmacies can become a meaningful player on this quest.

Progress requires committing to health equity as a systemwide goal and taking collective action across the

industry. The headwinds that may come along the way, including an uncertain economy, conflicting incentives, or staffing challenges, should not derail the efforts as long as the commitment is strong.

By viewing community pharmacies as partners rather than vendors or competitors, and by creating the necessary conditions, payers and providers can harness the collective power of the health care ecosystem to make significant strides in reducing health inequities and improving overall population health.

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