

**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
COVID-19 HEALTH EQUITY TASK FORCE**

3rd MEETING (Virtual)

April 30, 2021

Members Present

Marcella Nunez-Smith, MD, MHS (Chair)
Mayra Alvarez, MHA
James Hildreth, PhD, MD
Andrew Imparato, JD
Victor Joseph
Joneigh Khaldun, MD, MPH, FACEP
Octavio Martinez, MD, MPH, MBA, FAPA
Tim Putnam, PhD, DHA, EMS
Vincent Toranzo
Mary Turner, RN
Homer Venters, MD
Bobby Watts, MPH, MS
Haeyoung Yoon, JD

Members Absent

None

Federal Ex-Officio

Sara Bleich, PhD
Jessica Cardichon, JD
Angela Hanks, JD
Rachel Levine, MD
Eric Nguyen, JD

Federal Staff

Minh Wendt, PhD, Designated Federal Officer, Office of Minority Health
Martha Okafor, PhD, Executive Director, Office of the Assistant Secretary of Health

Invited Presenters

Rachel Levine, MD, Assistant Secretary for Health, Department of Health and Human Services
Arthur C. Evans Jr., PhD, Chief Executive Officer, American Psychological Association
Maysa Akbar, PhD, Chief Diversity Officer, American Psychological Association
Niranjan Karnik, MD, PhD, The Cynthia Oudejans Harris Professor, Associate Dean, Rush
University Medical Center

Call to Order, Welcome and Introductions

Minh Wendt, PhD

Designated Federal Officer, Office of Minority Health

Dr. Wendt opened the third meeting of the COVID-19 Health Equity Task Force (HETF) by welcoming the HETF chair and members as well as the invited speakers. She reminded attendees that the meeting was open to the public, that the meeting was being recorded and will be available for viewing at a later time, that all materials presented in this meeting will be available at minorityhealth.hhs.gov/hetf, that closed captioning for the meeting was available both from hhs.gov/live and the Office of Minority Health YouTube channel, that American Sign Language interpreters were available for the meeting, and that written comments will be accepted up to seven days after this meeting.

Opening Remarks

Marcella Nunez-Smith, MD, MHS

Chair, COVID-19 Health Equity Task Force

Dr. Nunez-Smith introduced the meeting by stating its objective: to discuss interim recommendations on advancing behavioral health equity. This shift toward behavioral health reflects the inequities affecting minority and marginalized populations during the COVID-19 pandemic including suffering from grief, stress, and economic worry. She highlighted specific subgroups that have been uniquely affected, including (1) children and older adults who may be struggling with social isolation and loneliness; (2) women and women of color who are overrepresented among essential workers; and (3) women who have exited the workforce due to caregiving demands. Each subgroup potentially faced additional challenges in receiving behavioral health care due to difficulties in finding providers, available services, and broadband access to connect to tele-healthcare.

Dr. Nunez-Smith reminded attendees that the task force's global charge is to provide specific recommendations to the President to mitigate the health and social inequities that are driving an unequal burden of disease and risk suffering, particularly in minoritized, marginalized, and medically underserved communities. She noted the importance of recognizing and naming both historical and contemporary structural realities. She added that the task force is charged with using disaggregated and intersectional data as well as the expertise of people with lived experiences.

After thanking the invited guests and the subject matter experts, Dr. Nunez-Smith noted that the task force's four subcommittees have developed interim recommendations for consideration that address issues related to communication and collaboration; data analytics and research; health care access and quality; and structural drivers and xenophobia.

After Dr. Nunez-Smith's opening remarks, Dr. Wendt performed a roll call of HETF members.

Updates from HHS

Rachel Levine, MD

Assistant Secretary for Health, HHS

Dr. Levine greeted the HETF members and thanked them for working toward the mitigation of health inequities as well as the prevention of future inequities, emphasizing the disproportionate impact of the pandemic on the health of racial and ethnic minority groups and economically disadvantaged persons. She added that HHS aims to ensure and maintain the behavioral health of health care workers as they combat COVID-19 by addressing emergency mental and behavioral health needs as well as preventative actions to mitigate human suffering. She noted that HHS has taken several critical steps to expand access to mental health and substance use disorder (SUD) services.

To assist people who lack health insurance, the American Rescue Plan allows enrollees in Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP) may apply to receive additional medical care via telehealth services including mental health counseling. Eligible individuals may apply through August 21, 2021, to gain access to these services. In addition, funding has been directed to substance abuse prevention and treatment, paired with new practice guidelines to expand the administration of buprenorphine, used to treat opioid use disorder, in primary care services.

During this time of increased urgency, HHS continues to ensure that proper funding and guidelines are in place to provide pathways to prevention, intervention, treatments, and recovery services, particularly for chronically underserved populations.

Panel Discussion

Three invited speakers, Dr. Maysa Akbar, Dr. Arthur Evans, Jr., and Dr. Niranjana Karnik, presented on the challenges and inequities that have been exacerbated by the COVID-19 pandemic and the impacts of the pandemic on mental health and mental health treatment. The presentations were followed by a brief discussion period.

Addressing the Behavioral Health Consequences of the COVID-19 Pandemic on Communities of Color

Arthur Evans, Jr., PhD, CEO, American Psychological Association

Maysa Akbar, PhD, Chief Diversity Officer, American Psychological Association

Dr. Evans acknowledged that COVID-19 has had an enormous impact on mental health in the United States and that recovery from the pandemic must address psychological wellbeing. Pre-existing issues involving systemic racism have further complicated and exacerbated the negative mental health impacts of COVID-19 on communities of color, and existing health paradigms are inadequate to address the breadth and complexity of the pandemic. The pandemic has underscored the significance of disparity within the United States, which has heightened psychological stress among the individuals affected. This stress, paired with increasing economic stress, has diminished many people's mental wellbeing since the start of the pandemic. An annual survey distributed by the American Psychological Association (APA) documented a sustained rise in stress levels across the nation, the first such rise in more than a decade. Dr.

Evans noted that 80 percent of Americans describe the pandemic as a source of stress, and an increasing number of people are reporting symptoms related to anxiety and depression. In addition, the number of drug-related overdoses and intimate partner violence have increased, each of these issues disproportionately affecting communities of color.

To describe the complex intersection of COVID-19-related health disparities and existing racial trauma, Dr. Akbar first defined racial trauma as “the cumulative effects of racism on an individual’s mental and physical health,” which has been linked to feelings of anxiety, depression, and suicide, as well as physical conditions such as high blood pressure and obesity. Racial trauma evolves across an individual’s lifespan and has been a chronic and pervasive problem in communities of color. By treating individuals and communities through an intersectional lens of racial trauma, the experiences of people of color can be humanized. Using a racial trauma–informed approach, recent research has shown that discrimination adversely affects health throughout the lifespan. Communities of color not only are affected by COVID-19, but also face compounding challenges that have been amplified by the pandemic.

Dr. Akbar noted that trauma and racism are intertwined and cannot be disconnected, adding that racial trauma is real. A study of suicide patterns in the state of Maryland found that, during the pandemic, completed suicides among individuals who identified as Black doubled, while completed suicides by individuals identifying as white halved. Mental health consequences and experiences of trauma in children and adolescents will be important to address as they prepare to return to school. COVID-19 has exacerbated the behavioral health challenges (e.g., loneliness and social isolation) for children of color. During the past year, mental health–related ER visits of children increased by 66 percent. Dr. Akbar added that if social isolation continues, the mental health of children and adolescents will inevitably suffer. COVID-19 has also led to long-term impacts on learning loss, contributing to the preexisting education gap experienced by students of color.

Dr. Akbar closed her portion of the presentation by describing racism’s involvement in adverse childhood experiences (ACEs). With the combined effects of racial trauma and COVID-19, greater than 10 percent of Black children have experienced at least one individual or interpersonal act of racism against them. Due to the lasting impacts an ACE could have on a child when contextualized, the prevention of ACEs, particularly more than two, could prevent up to 1.9 million cases of heart disease and 21 million cases of depression. Dr. Akbar stated that destigmatized mental health care and increased access to behavioral health care and treatment for racial trauma should be the civil right of every person of color. A multilayer commitment will be required to address racial trauma as well as COVID-19 in combination with a paradigm shift and innovative approach to mental health equity.

Dr. Evans offered an alternative framework to thinking about behavioral health. In the current paradigm, it is primarily people with a mental health diagnosis (i.e., roughly 25 percent of the U.S. population) who have access to mental health resources. Therefore, most of the U.S. population has no access to mental health resources, including opportunities for prevention and early intervention. Dr. Evans noted that this reactive system assumes that people without a mental health diagnosis have no clinical needs; although mental health exists on a continuum, many services are not available until an individual is in crisis.

Using a population health approach, the population is divided into three categories including individuals with a mental health diagnosis, individuals at heightened risk for mental health issues, and individuals who are generally healthy. For those in the diagnosed category the goal is to make available effective and efficient clinical care. For those at risk, the goal is to mitigate risks and intervene early. For those in the healthy category, the strategy is to promote and maintain psychological health.

Based on the findings and analyses described, the APA has developed recommendations for five critical domains, which will be submitted in full to the Health Equity Task Force in writing.

1. Strengthen the current mental health and SUD treatment system infrastructure.
2. Utilize a whole government approach to address the impact of COVID-19 on the behavioral health of communities of color.
3. Enhance research and data collection efforts.
4. Implement prevention and early intervention strategies.
5. Build community resilience.

The full recommendations provide a series of examples ranging from telehealth expansion to mental health parity. Within the second domain, Dr. Evans emphasized a need to address social determinants of mental and behavioral health, because 90 percent of individual health is determined by factors outside of health care (e.g., housing). The third domain promotes a data-driven approach to understanding disparities across communities and geographic areas. This approach will support the fourth domain and help to implement early intervention strategies to support individuals at risk for with mental health issues. The final domain builds upon the existing resilience of communities. Dr. Evans articulated his belief that each community holds the wisdom to solve its unique problem and should receive the resources to do so.

Interventions for Addressing Inequities of Behavioral and Mental Health impacted by COVID-19

Niranjan Karnik, MD, PhD, The Cynthia Oudejans Harris Professor, Associate Dean, Rush University Medical Center

Dr. Karnik focused his comments on evidence-based actions and large-scale interventions that can help to address inequities related to mental health in the context of COVID-19. He highlighted two solutions based on his most recent COVID-19 data. The first is the Common Elements Treatment Approach (CETA), developed by Dr. Laura Murray as a basic version of Cognitive Behavioral Therapy (CBT) that can be employed by laypersons with basic training. This type of first-line intervention could quickly relieve any cause of generalized distress, and people who do not respond can be referred to a more advanced health care professional. Wider use of this approach across the country could generate a workforce of laypeople or community health workers. A similar intervention, Families Overcoming Under Stress (FOCUS), was developed for the Department of Defense and is used globally to build resilience among families dealing with stress. This program provides individuals with agency and culturally tailored interventions.

The second large-scale intervention is telehealth, which has been promoted by researchers for years. Legislative action is needed to ensure that telehealth services become reimbursable and sustainable over time. As Dr. Levine mentioned, the ability of telehealth to expand access to health care services is constrained by a persistent digital divide, in which many American residents lack sufficient technological resources to access telehealth services. Clinicians across the country are now implementing evidence-based interventions via telehealth, improving their scalability and avoiding barriers that prevent in-person participation (e.g., in clinical trials). A public-private partnership with technology companies could bridge the digital divide and help to eliminate “internet deserts.” Broadening access to health care services would also broaden employment opportunities to provide these services. Individuals who become community health workers and peer recovery specialists often describe their work as deeply meaningful and impactful, and frequently take steps to increase their skills to become social workers and nurses.

Dr. Karnik described the combination of CETA and expanded telehealth interventions as a data-driven precision medicine approach. Researchers can use digital tools for assessment, analyze the resulting data to measure individual risk, and determine appropriate levels of care and providers of care. Frequent assessment can enable adjustment and personalization of the care received. Digital interventions can also be deployed in targeted situations. However, they are not a panacea; they must be combined with care, coaching, and counseling. Dr. Karnik reiterated that this shift in care must be done in a bold manner, because a piecemeal rollout could further entrench fractured systems.

Discussion

Dr. Tim Putnam asked Dr. Karnik whether the interventions presented would function if delivered by a peer support specialist. Dr. Karnik affirmed that the CETA program would likely work well in a peer support context (it has been tested in groups that lack formal education).

Dr. Octavio Martinez asked Dr. Akbar whether any data are available about the level of grief experienced by children, particularly children of color, who lost a parent due to COVID-19. Dr. Akbar stated that investigations of grief and its long-term impact on children remain in the early stages.

Mr. Andrew Imparato asked speakers to comment on the connection between mental health and employment. Dr. Evans noted that employment is an important aspect of treatment for individuals with mental health challenges. Research indicates that 80 percent of individuals with a serious mental illness want to work, although only 20 percent are employed. From a service standpoint, Dr. Evans noted that supported employment is critical, especially when individuals transition from an institutionalized setting. Dr. Karnik added that the stigma surrounding mental illness and substance use disorder in the employment context persists, and that the expansion of substance abuse treatment programs and hiring of peer support leaders has been hindered by hiring criteria that exclude individuals with a history of substance abuse. Further, most individuals who have lost their employment during the pandemic are still looking for new employment. Research indicates that individuals with mental health issues face serious challenges obtaining gainful employment.

Mr. Vincent Taranzo asked the presenters about possible explanations for the increased suicide rates among Black youth during the pandemic. Dr. Karnik noted that the dynamics of teen suicide are complex and that explaining suicide patterns across such a large population is difficult. He described certain stressors, such as those related to structural racism and social determinants of health, that may be impacting Black youth disproportionately.

Dr. Joneigh Khaldun asked Dr. Karnik how CETA is administered in practice and how it differs from mental health first aid. Dr. Karnik stated that CETA focuses on providing mental health treatment by training and supervising individuals who can facilitate care. Mental health first aid can reduce stigma around mental illness but is not a treatment and has no clinical impact. CETA has demonstrated the ability to reduce anxiety, depression, and substance abuse. CETA also draws upon CBT modules so that individuals with limited education in providing mental health care can provide a portion of care.

Ms. Mary Turner asked Dr. Karnik about long-term solutions to training more people of color to become psychiatrists and psychologists. Dr. Karnik confirmed the importance of increasing access to such training pathways, but noted that expanding the number of individuals holding doctorates may be too narrow a solution. Nurse practitioners and people from a variety of backgrounds should be welcomed into training cohorts. People should be able to follow a stepwise approach to enter a profession that does not require the commitment of time and resources to earn a graduate degree. A stepwise approach could also diversify the health care workforce. Dr. Akbar provided specific recommendations to increase the number of people of color in the psychology and psychiatry fields. She suggested that federal funds be provided for scholars and scientists of color to conduct the appropriate research on racial trauma, healing, and other areas that affect communities of color. Further, she highlighted funding pathways, like the Minority Fellowship Program (MFP), to support psychiatrists of color. In addition, Dr. Akbar noted the need for communities of color to rethink how they view their own resilience, which could lead to greater strength and empowerment.

Introduction of Ex-officio Members

HETF members briefly introduced themselves, summarized their backgrounds, and highlighted any experiences relevant to the HETF charge.

Dr. Sara Bleich, Senior Advisor for COVID in the Office of the Secretary at U.S. Department of Agriculture, has a background in public health.

Ms. Jessica Cardichon, of the U.S. Department of Education and the Office of Planning, Evaluation, and Policy Development, has been investigating differences in the rates of return to school.

Ms. Angela Hanks, Counselor at the Secretary's Office in the Department of Labor, investigates disparate impacts of COVID-19 on the workforce, particularly related to wage flexibility, employment, and remaining safe at work.

Mr. Eric Nguyen, Senior Counsel in the Office of the Deputy Attorney General in the U.S. Department of Justice, is interested in systemic disparities and inequities in the justice system, particularly for people in custody of the Bureau of Prisons and the U.S. Marshals Service.

Dr. Rachel Levine, introduced above, is the Assistant Secretary for Health in the U.S. Department of Health and Human Services.

Subcommittee Presentations

Dr. Okafor introduced the four HETF subcommittees: (1) Communications and Collaboration; (2) Data, Analytics, and Research; (3) Healthcare Access and Quality; and (4) Structural Drivers and Xenophobia. Since the last HETF meeting, the subcommittees were tasked with identifying interim recommendations for mitigating the mental and behavioral health inequities caused or exacerbated by the COVID-19 pandemic and methods to prevent future inequities that may exist in response to the pandemic. The interim recommendations were developed in consultation with subject matter experts and span four broad themes: (1) mandating data collection, harmonization, and integrity; (2) increasing access to mental health services in marginalized communities; (3) engaging communities; and (4) protecting working families.

Further, the interim recommendations address (1) how agencies and officials can best allocate resources, given disproportionate rates of COVID-19 infection, hospitalization, and mortality, and disparities in COVID-19 outcomes by race, ethnicity, and additional factors; (2) how relevant agencies can disperse COVID-19 relief funds in a manner that advances equity; and (3) how relevant agencies can ensure effective, culturally aligned communication to communities of color and other underserved populations.

Subcommittee chairs presented their interim recommendations, which will be further refined to produce a set of final recommendations for the HETF to present to President Joseph R. Biden.

Structural Drivers and Xenophobia Subcommittee

Haeyoung Yoon, JD

The Structural Drivers and Xenophobia Subcommittee's charge is to identify actionable recommendations to address the rise in xenophobia, particularly against Asians, Asian-Americans, Pacific Islanders (AAPI) and Native Hawaiians (NH) during the pandemic, as well as systems and policies that have contributed to or exacerbated COVID-related health inequities, especially in marginalized and underserved communities that have been hit hardest by the pandemic. The Subcommittee investigated social determinants of health and wellbeing such as transportation, employment, income, nutrition, and safe housing to identify the problems affecting different communities. To address mental and behavioral health, the Subcommittee identified six issues and developed corresponding recommendations.

The Subcommittee formulated six problem statements. The first addresses xenophobia—making a direct connection between the alarming rise of hate crimes committed and acts of discrimination against the AAPI and NH community and addressing the negative impacts this discrimination has on AAPI mental health. The second addresses economic insecurity due to job loss or reduced work hours, working under hazardous conditions, and/or lack of valid

immigration status, which can contribute to increased stress and anxiety for workers. The third addresses housing insecurity in both rural and urban areas of America and the negative mental health impacts that may accompany stress about eviction, sheltering in a home with poor conditions, or the inability to self-isolate, especially in multi-generational households. The fourth notes that the COVID-19 pandemic has exacerbated persistent racial and ethnic inequities that contribute to poor mental health. The fifth addresses people struggling with SUDs or mental illness that disproportionately face criminal or disciplinary consequences when access to treatment is needed. The sixth addresses food insecurity and improper nutrition, which have been worsened by the pandemic.

To address the first problem statement, the Subcommittee presented the following recommendations:

1. The federal government should increase federal funding to support local governments and community and health organizations that work directly with survivors of violence and groups that create community-driven solutions.
2. The federal government should strengthen anti-discrimination protections for AAPI and NH communities and support investigation and prosecution of hate crimes, including the COVID-19 Hate Crimes Act.
3. The federal government should promote inclusion of histories, cultures, and experiences of diverse AAPI and NH communities in elementary and secondary school curricula, and development of ethnic studies programs in tertiary education levels.

To address the second problem statement, the Subcommittee presented the following recommendations:

1. The federal government should work to pass jobs and economic recovery legislation to ensure that all working families can earn family-sustaining wages, have access to benefits (e.g., health insurance, paid time off), and receive strong worker protections to improve their economic security and opportunity.
2. The federal government should direct the Department of Labor to issue the emergency temporary health and safety standard to protect workers from hazardous COVID-related working conditions.
3. The federal government should increase funding for worker protections so that federal labor and employment agencies have sufficient resources to protect workers from hazardous and substandard working conditions.

Ms. Yoon noted that the Biden Administration issued an executive order directing the Department of Labor to address the third recommendation. However, the March 15 deadline to increase funding for worker protections has passed; the Subcommittee urges the Administration to address this important labor standard.

To address the third problem statement, the Subcommittee presented the following recommendations:

1. The federal government should fund housing assistance, including the renewal of the eviction moratorium.
2. The federal government should continue to support quarantine shelters to prevent the spread of COVID-19 for people living in congregate housing, or those that need shelter (e.g., unhoused, or multigenerational housing)
3. The federal government should prohibit local housing authorities from disqualifying individuals from eligibility for Housing and Urban Development (HUD) vouchers funded under the American Rescue Plan or CARES Act on the basis of criminal drug history.

To address the fourth problem statement, the Subcommittee presented the following recommendations:

1. Invest federal funding in the development of a racially, ethnically, and culturally diverse mental health workforce that includes a full range of licensed health care professionals; acknowledge structural urbanism and establish programs, policies, and funding to support thriving rural communities, including clinical, treatment centers, rural hospitals, and mobile health vans to transport licensed health care professionals to where they are needed.
2. Develop a broad public awareness campaign focused on increasing knowledge of mental health and SUDs among children, youth and adults; partner with school districts, Integrated Health Enterprises (IHEs), and community-based organizations (CBOs) to implement the campaign to reduce the stigma surrounding mental illness.
3. Invest in expanding affordable broadband internet access to low-income and rural communities; invest in people, processes, support, and regulations for telehealth/tele-psychiatry and education.
4. Increase funding for tribal early childhood programs with culturally and linguistically competent responses to address wellbeing.

To address the fifth problem statement, the Subcommittee presented the following recommendations:

1. Shift responses to mental health crises from disciplinary responses by law enforcement to community driven and health-oriented crisis response teams.
2. Enact health insurance payment policies for substance abuse treatment.
3. Provide alternatives to law enforcement responses to apparent mental health conditions and crises.
4. Both psychological and medical issues must be assessed by a licensed health professional.

To address the sixth problem statement, the Subcommittee presented the following recommendations:

1. Build a stronger and more resilient nutrition safety net that is responsive to the co-occurrence of food insecurity and diet-related illness, be better prepared to protect the most vulnerable citizens generally and against future pandemics or unforeseen circumstances.

2. Leverage technology to maximize participation, retention, and streamline onboarding in federal nutrition assistance programs to create a simplified system that provides convenient access.
3. Expand access to healthier food and beverage choices across nutrition assistance programs and apply the latest nutrition science.
4. Expand access to online grocery shopping, particularly for program participants in areas with limited access to healthy food options.
5. Strengthen local and regional food production by providing flexibility in production and distribution—this shift will open new revenue streams for farmers and help with the nation’s food assistance response.
6. Coordinate with Department of the Interior (DOI), Wildlife and Parks to authorize hunting and fishing openings to compensate for hardships brought on by the pandemic (e.g., increased cost of merchandise and freight).

Discussion

Mr. Victor Joseph requested insertion of “substance abuse” into the first recommendation under problem statement four. He also suggested including substance abuse wherever mental and behavioral health are mentioned.

Dr. Joneigh Khaldun suggested an amendment to the language in problem statement six, as well as addition of cross-enrollment of services to address infrastructure beyond technology.

Dr. James Hildreth added that health care workers who care for hospitalized patients need personal protective equipment (PPE) because SARS-CoV-2 is an airborne pathogen. However, many health care workers come from disadvantaged populations and therefore PPE availability is a health equity issue.

Data, Analytics, and Research Subcommittee

Joneigh Khaldun, MD, MPH, FACEP

The Data, Analytics, and Research Subcommittee’s charge is to explore how addressing issues related to collection, sharing, and use of data can improve the current COVID-19 response and drive equity for health care services overall. The Subcommittee formulated three problem statements. The first addresses the lack of data on the scope and drivers of the disproportionate impact of COVID-19 on mental health and SUD in all communities, particularly those who are marginalized, minoritized, or medically underserved (e.g., racial and ethnic minorities, LGBTQ populations, native and tribal communities). The second addresses the lack of data on the impact of COVID-19 on co-occurring disorders, SUDs, and overdose, and how COVID-19 may have widened disparities. The third addresses the lack of data on the impact of several structural and economic policy changes intended to expand access to health care services during COVID-19.

To address the first problem statement, the Subcommittee presented the following interim recommendations:

1. The federal government should collect, integrate, and share data related to mental health and SUDs.

- a. Data should be collected as it relates to COVID-19, including testing, hospitalizations, prescriptions, utilization of community-based therapy, ICU admissions, and fatalities. The data should be disaggregated by age, race, ethnicity, sexual orientation and gender identity, primary language spoken at home, disability status, and income level at the local, state, national, and tribal/territorial level to help understand the impact of COVID-19 on local communities and guide improvement and expansion of resources for mental health and SUD.
2. A robust analysis of the drivers of depression, increased substance use and suicidality, and the widening disparities identified during COVID-19 should be conducted.
3. The federal government should provide guidance to support research efforts that engage community members.
 - a. People with lived experience with mental health and SUDs should be involved in defining problems, gathering and interpreting data, and developing solutions.
4. The federal government should expand sample size and conduct targeted over-sampling within the National Health Interview Survey and other public health data systems that provide information about mental health, substance abuse, and suicide.
5. The federal government should convene an interagency group that promotes and aligns the collection, reporting, and sharing of data to understand and drive responses to prevent and treat SUDs and support the health and well-being of people living with mental health and SUDs.
6. The federal government should implement a robust analysis of the impact of COVID-19 on the mental health of all communities.
 - a. This analysis should include specifically how COVID-19 has impacted youth, health care workers, elderly, Black, Indigenous People of Color, LGBTQ+, religious minorities, people with disabilities, people who are incarcerated, and other minoritized, marginalized, and medically underserved communities.
 - b. The analysis should address the intersectionality across different groups.
7. The federal government should issue guidelines and provide resources to implement widespread mental health, SUD and interpersonal violence screening, including screening of children, health care workers, LGBTQ+, native and tribal populations, remote and or rural communities, people with disabilities, people living in congregate settings (including skilled nursing facilities, group homes, rehabilitation facilities, intermediate care facilities, homeless shelters, state hospitals, jails, and prisons), and the elderly.
8. The federal government should expand incentive programs to improve surveillance and the collection of data in public and private behavioral health services, psychiatric hospitals, and carceral settings.
9. The [federal] government should improve the collection of data on the AAPI and NH communities, including disaggregated data where feasible, to ensure a more accurate understanding and depiction of mental health in the AAPI community.
10. Stringent measures must be taken to ensure the security and privacy of all data.

To address the second problem statement, the Subcommittee presented the following interim recommendation:

1. The federal government should incentivize research that analyzes the impacts of COVID-19 on all SUDs and co-occurring disorders, including the disparate impact on minoritized, marginalized, and medically underserved communities.

To address the third problem statement, the Subcommittee presented the following interim recommendations:

1. The federal government should evaluate policy changes during the pandemic that expanded access to mental health care and SUD treatment.
2. The federal government should evaluate the efficacy and accessibility of expanded telehealth services in the context of the pandemic.
3. The federal government should evaluate the impact of the many structural and economic policy changes that were made during the pandemic, including those involving housing, criminal justice, and Medicaid.

Discussion

Mr. Imparato endorsed framing disability as a demographic variable rather than as an outcome. Mr. Venters added that the inclusion of data on incarcerated individuals will fill a current void, and that adherence to the Subcommittee's recommendations will enable tracking and mitigation of health risks for incarcerated individuals.

While acknowledging the desire to expand and improve the data that are collected across the country, Dr. Martinez highlighted that data sharing is critical, and many measures are already collected by the Centers for Disease Control and Prevention (CDC) and the U.S. Public Health Service that can be better utilized and integrated in a timely manner.

Regarding the third recommendation under problem statement three, which highlights the importance of housing policies and the eviction moratorium, Ms. Alvarez encouraged the Subcommittee to add that the health-related policy changes enacted during the pandemic have helped millions of Americans to maintain stable living conditions. She raised the example of Medicaid enrollees who received continuous coverage under the program and did not have to navigate eligibility redeterminations for eligibility, enabling many families to maintain preventative care services. Recognizing the importance of continuous health care coverage, Ms. Alvarez added that marginalized populations would benefit from inclusion of some health specifics to the recommendation.

Communications and Collaboration Subcommittee

Mayra Alvarez, MHA

The Communications and Collaboration Subcommittee's charge was to explore how issues related to communications, both within the federal government and with external, state, and local partners, can contribute to a more equitable response to COVID-19 and future pandemics. The Subcommittee formulated four problem statements. The first addresses the preexisting mental health crises that faced Americans before, but have been exacerbated by, the pandemic. The second addresses a subset of that problem, that is, that COVID-19 has intensified a preexisting mental health crisis among children and the child-serving workforce (teachers, early learning, and childcare professionals) who are not fully prepared to respond to the mental health impacts

on children and youth. The third addresses systemic racism, a root cause of mental health inequities, and the pervasive impacts of white supremacy on the wellbeing of all Americans. The fourth addresses social isolation, which, as a result of physical distancing and stay-at-home orders, has increased mental health challenges for many Americans.

To address the first problem statement, the Subcommittee presented the following interim recommendations:

1. The White House should identify opportunities to draw public attention to the mental health impacts of the pandemic emergency.
 - a. These include coverage of mental health and COVID-related information and coping mechanisms in the President's weekly address; a weekly fireside chat between the President and various mental health leaders (both within the government and with state and community leaders); and a Cabinet-wide meeting on the mental health implication of the public health emergency and opportunities to respond.
2. The federal government should support a robust collaboration between HHS and DOJ to invest in alternative to policing.
 - a. This includes mobile crisis teams and a release of guidance on alternatives to policing and requires appropriate input from individuals with lived experience to determine how funds should be utilized in the community.
3. The federal government should lead a multi-pronged public-private mental health awareness, education, and communications campaign.
 - a. The campaign should center equity and the unique impacts of the multiple pandemics on minoritized, marginalized, and medically underserved populations that have been disproportionately harmed by COVID-19.

To address the second problem statement, the Subcommittee presented the following interim recommendations:

1. The White House should launch a comprehensive initiative to support the children of people who have died from COVID-19, who are disproportionately Black and Brown children.
 - a. The initiative will partner with local and national leaders in philanthropy, business, government, faith communities, and media and will include the creation of an Interagency Task Force to work across executive departments and agencies to address the broad and multidimensional challenges facing these children.
2. The federal government, through robust collaboration between the Departments of Education and Health and Human Services, should offer guidance to school districts to inform the development of a comprehensive plan to address the potential mental health needs of their students, particularly through uplifting community schools and other systems of care approaches that center equity.
3. The federal government should invest in school-based health centers and strengthen its commitment to ensuring such centers are open to both students and families.
4. The federal government should fund a technical assistance collaborative and professional learning network to support early childhood learning, care, and development staff working with young children.

5. The federal government should invest in building states' capacity to support the hiring of more counselors and training of teachers and administrators on social-emotional learning techniques.
6. The federal government should invest in the availability of dyadic care models to strengthen access to whole child and family-centered mental health care services.
7. The federal government should invest in youth-led movement through grants for the integration of mental health into the programming of youth-led national organizations as well as support for existing youth-focused networks in states across the country.
8. The federal government should require states to have a youth mental health board, similar to the requirements included in Substance Abuse and Mental Health Services Administration (SAMHSA) Block Grants.
 - a. This requirement would allow young people to influence decision-making on the delivery of mental health services in response to the pandemic and also other child-serving systems.
9. The federal government should launch a national outreach and education campaign focused on young people, particularly Generation Z and younger populations, and include listening sessions across the country.
 - a. The campaign should utilize social media and other channels where youth are connected, as well as leverage existing peer-based programs.
10. The federal government should create the position of a "Youth Health Liaison" to work alongside the U.S. Surgeon General in shared efforts to uplift the mental health impact of the pandemic and ways to support young people.

To address the third problem statement, the Subcommittee presented the following interim recommendations:

1. The White House should host a *Syndemic* (racism, mental health, COVID-19) symposium (multiple crises) to draw attention to the multiple challenges and offer opportunity for dialogue and solutions.
2. Federal departments should strengthen collaboration with community-based organizations by providing robust funding for community-based organizations to celebrate and build cultural identity to prevent mental illness and help address mental health impacts of the pandemic. Organizations will have a demonstrated record of working with and for communities of colors, people with disabilities, rural communities, immigrants, LGBTQ+, and other marginalized communities with lived experience.
3. For a short term, federal departments should provide clear standards on best practices for reaching marginalized communities with mental health supports and services, including ways to eliminate structural barriers, and do so in partnership with trusted national partners with state and local reach.
4. The federal government should require the creation of community advisory boards for mental health as part of receiving funding for mental health interventions.
5. Departments should engage in a coordinated effort to fund peer support specialists (community health workers), including youth, to address the mental health impacts of COVID-19 and assist the public in accessing care and support. When necessary, peer support programs should supplement mental health and substance abuse treatment by licensed professionals, not supplant it.

To address the fourth problem statement, the Subcommittee presented the following interim recommendations:

1. The issue of social isolation should be integrated into a federally led, multi-pronged public-private mental health awareness, education, and communications campaign, centering equity and the unique impact of the multiple pandemics on minoritized, marginalized, and medically underserved populations that have been disproportionately harmed by COVID-19.
2. The federal government should launch a robust communications campaign around the availability, security, and quality of telehealth and its connection to the importance of accessing mental health services.
3. In the short term, the federal government should strengthen access to broadband internet through President Biden's infrastructure plan to minimize structural barriers to accessing mental health services via telehealth.

Discussion

Mr. Imperato commented on the power of young voices and raised the example of Amanda Gorman, the youth poet laureate, and strongly endorsed the recommendation to establish a youth health liaison to elevate the voices of young people. He expressed support for efforts that help young people develop their identities as a strategy to connect them to the broader community.

Dr. Martinez highlighted the need for communication-centric public-private partnerships and stressed that nonprofit and philanthropic organizations should be included in such partnerships.

Mr. Toranzo endorsed the incorporation of young American voices into the recommendations under the second problem statement and highlighted the strong desire of younger generations to eliminate stigma surrounding mental and behavioral health issues.

Healthcare Access and Quality Subcommittee

Tim Putnam, DHA, EMS

The Healthcare Access and Quality Subcommittee's charge was to explore how issues related to health care access and quality drive inequities. The Subcommittee formulated six problem statements that build upon the work presented by the previous committees. The first addresses pre-pandemic limitations to mental health care access among marginalized populations, which were exacerbated during COVID-19 by structural barriers that exist for these groups. Chronic underfunding and the lack of payment parity for mental health services has further worsened this inequity in care access. Several recommendations under this problem statement are specific to the needs of the Indian Health Service and Native American community. The second problem statement addresses the shortage of mental health care professionals, particularly people of color, in the United States. The third addresses the fact that young people have experienced significant disruptions during the pandemic at a key developmental time in their lives. The fourth addresses the trauma, anxiety, stress, depression, and emotional exhaustion (burnout) experienced by health care workers during the pandemic. The fifth addresses the fact that SUDs and overdose deaths have increased because of the pandemic, and many people with SUDs have been cut off

from their regular points of care. The sixth addresses the mental health impacts on inadequate health care access, which is exacerbated by the failure by many to recognize that health care is a human right.

To address the first problem statement, the Subcommittee presented the following interim recommendations:

1. The federal government should assess this payment system from a perspective of equity and create a process to resolve this discrepancy that leads to inequity of care. Enforce the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).
2. The federal government should target funding to programs in marginalized communities that recognize mental health care needs to be culturally responsive and appropriate with consideration of the nuances of systemic racism, discrimination, and other institutionalized biases.
3. The Office of the Inspector General (OIG) should create an Indian health care provider (IHCP) Safe Harbor akin to the FQHC Safe Harbor that allows tribal health providers to provide devices for telehealth.
4. Expand Self Governance replacing the competitive behavioral health grant funding mechanism to contract and or compacts.
 - a. Request that the HHS Secretary as authorized by the Indian Self Determination Education Assistant Act (ISDEAA) examine the feasibility of applying Title 5 to other agencies across HHS.
5. Increase access to clinical treatment during behavioral health crises, especially in communities and settings where a law enforcement response predominates.
6. Increase immediate funding to Medicaid and Medicare providers in marginalized populations along the pathways of licensed health care professionals' reimbursement rates, peer support programs, and social determinants of mental health.
 - a. Peer support programs should supplement mental health and substance use treatment by licensed professionals, not supplant it.
7. Centers for Medicare & Medicaid Services (CMS) to authorize telehealth in Medicaid; particularly telephonic delivery and reimbursement for audio-only Medicaid behavioral health services when dependable and effective video-based telehealth is unavailable.
 - a. Address the barriers and disruptions to mental health services during the COVID-19 pandemic through telehealth and with the expansion of health care coverage and access among others.
 - b. Increase access to in-person mental health treatment with mental health professionals by ensuring sufficient PPE, ventilation, and other protection to mitigate potential exposure to COVID-19.
8. Increase funding to domestic violence shelters that primarily serve marginalized communities.
9. Expand supportive housing and housing-first type programs.
10. Increase funding for mental health research specific to marginalized communities, youth, and health care workers through all applicable federal programs.
11. Increase the availability of mental health resources to greatly reduce suicide risk among marginalized populations, *specifically youth*.

- a. Federal government to increase funding for suicide interventions through faith-based and community organizations.
 - b. Increase access to on-demand telehealth and in-person care for suicide assessment, intervention, and prevention in hospital emergency departments, community centers, and schools.
12. Target mental health care funding based on need, including education of culturally responsive licensed mental health professionals, and medical offices, clinics, and psychiatric beds.

To address the second problem statement, the Subcommittee presented the following interim recommendations:

1. Fast-track immigrant health care professionals who face significant barriers to practicing their profession.
2. Offer marginalized community members grants, scholarships, federal loan repayment programs, and clinical training to increase the number of culturally licensed mental health professionals.
3. Expand the role of peer navigator and support programs designed to increase mental healthcare capacity.
 - a. Peer support programs should supplement mental health and substance use treatment by licensed professionals, not supplant it.
4. Develop a nationwide service to provide resources to primary care providers and psychiatric medical professional to support Collaborative Management (CM) program and similar mental and behavioral health and primary care collaborations.
5. Federal funding should be targeted toward a system that corrects inequities and supports youth in marginalized communities.
 - a. This system should also include support for parents in marginalized communities.
 - b. Federal government should increase its investment in programs with documented success in increasing representation of underrepresented communities, like Minority-Serving Institutions (MSI), Tribal colleges, and Historically Black Colleges and Universities (HBCUs).

To address the third problem statement, the Subcommittee presented the following interim recommendations:

1. Ensure young people have access to comprehensive mental health services and grief counseling from licensed health care professionals to deal with the mental health effects of the pandemic.
2. Formalized guided peer support programs should be part of the federal response for youth.
3. Programs to treat more severe mental illness should be operated and distributed through federally funded health centers and rural health clinics, primary care and pediatrician offices, and schools to increase support for screening, education, and referrals.

To address the fourth problem statement, the Subcommittee presented the following interim recommendations:

1. Formalized guided peer support programs should be part of the federal response for health care workers.
2. Protect frontline worker's health and safety in the workplace through the issuance of an OSHA Emergency Temporary Standard on COVID-19 to create standard guidelines for protecting all workers from COVID-19.
3. Ban the reuse of single-use PPE and ramp up PPE production with the Defense Production Act (DPA).

To address the fifth problem statement, the Subcommittee presented the following interim recommendations:

1. Encourage states to adopt Drug Enforcement Agency (DEA) guidance authorizing physicians to start buprenorphine treatment via telephone evaluation.
2. Allow states to get blanket exemptions from SAMHSA to allow patients to receive take-home doses of medication for opioid use disorder.
3. Remove requirements of 1:1 exchange at needle exchange sites during the COVID-19 emergency.
4. Pilot and fund harm-reduction initiatives, while centering community involvement and health equity.
5. Explore empirical implications of drug decriminalization and regulation as part of an end to the war on drugs, the promotion of a safer drug supply, and reduction in mass incarceration.
6. Massive scale-up of the federal financial investment into substance use treatment, prevention, and harm reduction services and pass legislation like the CARES Act of 2020.

To address the sixth problem statement, the Subcommittee presented the following interim recommendations:

1. Declare health care access and coverage a human right.
2. Align federal policies and funding to secure this right.

Discussion

Ms. Turner expressed her gratitude to see health care recognized as a human right. She added that many ICU admissions could have been avoided if preventative health care had been available.

Mr. Toranzo noted that trauma can result from the loss of a family member, which has been a common occurrence throughout the pandemic. He added that a lack of health care access has weakened the American response to the pandemic and exacerbated the U.S. mental health crises. For many individuals, particularly frontline workers who are more frequently people of color, tying health care coverage to employment is not a benefit but a liability. He noted that this Subcommittee recommends that the federal government recognize health care as a human right.

Dr. Venters further explained the comments of previous speakers regarding the justice system's response to a health problem, noting that this approach often leads to negative outcomes and perpetuates health disparities. Individuals with a health problem must be treated with a health response.

Mr. Joseph recommended that Tribes and Tribal organizations be treated equally with U.S. states in the language of the above recommendations as they are finalized.

Public Comments

Thea Monyee, Healthy Equity Policy Group

Good afternoon and thank you to this committee. My name is Thea Monyee and I am honored to speak as a representative of the Health Equity Policy Group. This group is a cohort of black female health, mental health, research, biomedical, legal, substance use, behavioral, and community engagement strategist. Our focus is to address health inequities and disparities in Black America. Thank you for all the work and expressed intentions shared here today. It is exciting to hear. Mental health in America can be used as a mirror to reflect who we are as a society and what we value. The Black communities' conflict with America's mental health system is not solely due to stigma or faith-centered beliefs and practices. It is due to righteous suspicion. The American mental health system is designed from a Eurocentric model and value system focused on the individual rather than an Afrocentric system of integration where everything is connected. So what is the challenge? The current mental health model is designed at best to teach Black bodies to cope with systemic oppression, violence, and inequity while simultaneously educating and training practitioners to believe they are incapable of harboring bias or being a tool of a systemic racism system. One example is how providers of color are scarce and are trained within a system centering white clients and their cultural norms. Another is how practitioners are discouraged from implementing culturally relevant healing practices unless they are sanctioned and deemed acceptable by white leaders in the mental health field. Some of the solutions could be creating mental health resources and models that understand that black communities thrive in spaces that center their cultural values, including creativity, community, and spirituality. We deserve to see our community members and values integrated into this current model. The mental health field must shift from neutrality to directly addressing systemic oppression in and out of the therapy room in order to meet the standards, we recommend mental health, professional associations and governing bodies to attract and retain diverse cultures, perspectives and beliefs to create and implement culturally and socially equitable guidelines, ethics policies, education standards, assessment tools and treatment that are created for and by us. We must make joy the baseline standard for all areas of health when engaging with Black communities. Create a modifier for racism within the DSM, naming it as undoubtedly the most stressful environmental factor Black America is facing. In closing, the current individualistic model of mental health fails to acknowledge the impact of systemic racism on Black bodies, which includes micro invalidation, micro aggression and micro inequities. We cannot equitably address the mental health needs of Black people in America unless we begin by valuing of them in all areas of society and acknowledging that the number one problem of Black communities faced in America, including in mental health, is white supremacy. Thank you so much for this opportunity.

Kenneth Westbury, National Coalition of STD Directors

My name is Kenneth Westbury and I am with the National Coalition of STD Directors, it is both a membership organization that represents public health specialists, and contact tracers in all 50 states and territories. We commend the efforts of the taskforce to sustain prioritization on the needs of traditionally underserved minority communities and those most desperately affected.

Due to audio difficulties, Dr. Wendt noted that Mr. Westbury's statement will be followed up with written comment.

Victoria Veltri, Connecticut Office of Health Strategy

Good afternoon, Dr. Marcella Nunez-Smith and members of the COVID-19 Health Equity Task Force. I'm here on behalf of the state of Connecticut and our Office of Health Strategy where our mission is to implement comprehensive, data driven strategies that promote equal access to high quality health care costs and ensure better health for the people of Connecticut. I'm not going to read my full public comment that I submitted to you, but I will highlight a few areas. One is you have made an interim recommendation on mandating data collection, harmonization and integrity in collaboration with marginalized communities and practitioners. We couldn't endorse that proposal more. While your proposals are tied to the disparities particularly faced by communities of color, disabled individuals during the pandemic. I urge you and we urge you to recommend such data collection across all settings on a permanent basis. The collection of such data has been a priority since our offices inception and aligns with our governor, Governor Lamonts priority on addressing equity communities in Connecticut, experiencing serious disparities in clinical and population health outcomes and communities are suffering disproportionately on maternal morbidity, asthma, diabetes and particularly in COVID-19. Disparities by disability and insurance status are well documented. In some counties of Connecticut over sixty-five languages are spoken. We're no different from other states in this regard, and in some cases our disparities are worsened by substantial economic inequality. Without standard and uniform data collection, we cannot understand, identify and target resources and optimal interventions and solutions to the disparities that exist. In Connecticut in 2021 our office introduced legislation to clarify and standardize race, ethnicity and language data collection for hospitals and health care providers required to connect to our state's health information exchange. And that includes meaningful disaggregation to address long standing issues of racism and implicit bias in health care delivery and health care systems, our proposal doesn't mandate that patients provide this information. But hospitals and health providers must request it and include these data in their electronic health records for inclusion in the state's HIE, where reporting is critical for discrete public health uses such as vaccine and testing reports a focus on collection by providers as part of an HIE as the promise of a further reach and interaction with other data sources such as immunization registries and state agency data collection. Disaggregation is the key to making communities and their unique experiences visible in addressing ongoing structural discrimination. Quick example, in Connecticut, we have a large Cambodian American community, which many are survivors of the Khmer Rouge, their experiences and some of their common health conditions, PTSD, diabetes, hypertension, high suicide rates and high early mortality rates would be very different from other Asian communities in Connecticut who have their own unique experiences. OHS proposed this language on statewide HIE, self-reported data collection that included disaggregation, multiple categories, including the choice to select multiple ethnic or racial designations and the required collection of primary language data. We know this is possible because we've done it in Connecticut, and we are trying to recommend that providers collected more uniformly across the country and in our state. But they need resources, and they need help to do it. Lots of health care providers and health systems can do this on their own. Harvard health care has done in

Connecticut, but they need to support lots of smaller providers, need resources. So, we wholeheartedly endorse your recommendation to provide resources at a federal level, including the kind of technical assistance to help providers understand how to interact with patients and how to use it in reporting for reporting purposes. Obviously, these data are critical at an aggregate level to target interventions and direct resources in the future. So, we are very supportive of this work. We are actually developing a health equity trust here in Connecticut to address upstream interventions and the collection of these data are critical to that work. Finally, I will close by saying we are more than willing to be a partner with you as you move forward. We're happy to do that and support your work. And I want to say, just as a person who's been listening for the last two hours, that the issues that you've discussed during the meeting so far are very near and dear to my heart and in the state of Connecticut as we address them routinely on a daily basis. So, we also are very happy to see the recommendations coming forward in the areas you trust today. So, again, thank you very much for the opportunity to be here. And thank you so much for the work you're doing.

Jessica Halem, Tegan and Sara Foundation

Thank you. Thank you so much. I'm sorry to disappoint any of you that were hoping that Tegan or Sara, the world-famous pop stars and queer icons, would be here today. But I am proud to be representing the entire board and staff of the Tegan and Sara Foundation, whose mission is to improve the lives of LGBTQ women and girls. With the help of our amazing network of small and grassroots grantees and partners. We recently fielded an online survey focused on the LGBTQ community and the covid-19 vaccine. And I wanted to share some early results with you right away. My comments today and the full report that you have access to will focus on three thousand three hundred and thirty-eight respondents who are 90 percent LGBTQ and who provided a US zip code between the dates of March 31 and April 13. So, I'm going to highlight three bright spots today that I think we could all use and maybe learn from as well. Number one, the US LGBTQ population is highly accepting of the covid-19 vaccine. In our survey, sixty eight percent were already vaccinated. That means that two out of three of our respondents had already been vaccinated. By mid-April, this is fascinating because our respondents were disproportionately younger right under the age of fifty-five. This may be, of course, related to the increased likelihood that LGBTQ people work in industries that were highly affected by the covid-19 crisis. Much more research is needed here. Of the remainder, eighty four percent want to get the covid-19 vaccine as soon as possible. So let the public records show that the gay community is excited about summer. Bright spot number two gender minority people, which includes those who identify as non-binary or transgender, were the most likely of all of our respondents to want to get the vaccine as soon as possible. Given the lower levels of health care among and access among gender minority people, what can we learn from this story, the success of this vaccination effort among those who are gender minority, perhaps lowering the barriers to life saving medications and screenings works and perhaps this sort of drive through nature of most vaccine sites offers less misgendering and trauma for trans and non-binary people. And number three, and really the headline for today's story is that the message was clear, wanting to protect others is the most important reason cited by LGBTQ people who have gotten vaccinated or who will get vaccinated. This was substantially higher than among cis and straight people. And of course, this is the LGBTQ story that even after our long history of trauma and discrimination and now once again, we are being used as political football on the state level, we

care deeply about the health of each other, and we'll do whatever we can to protect our community. Finally, because sexual orientation and gender identity or what we call SOGI data are not collected in real time the impact of covid-19 on the LGBTQ population is less understood. I know all of you hope that we will fix this data issue quickly at the federal level. Thank you all so much for having me.

Interim Recommendations Vote

Dr. Nunez-Smith introduced the voting phase for HETF members to vote on each set of interim recommendations and whether the recommendations should move forward to the next stage for refinement. Dr. Nunez-Smith opened the floor for consideration of the following interim recommendations:

- Structural Drivers and Xenophobia Subcommittee recommendations
- Data, Analytics, and Research Subcommittee recommendations
- Communications and Collaboration Subcommittee recommendations
- Healthcare Access and Quality Subcommittee recommendations

Each recommendation received a motion to approve that was seconded. Each motion carried with a majority vote to approve. The four subcommittees will consider the friendly amendments noted in the discussion sections above as they further refine the recommendations.

Closing Remarks and Next Steps

Marcella Nunez-Smith, MD, MHS

Dr. Nunez-Smith thanked the HETF members, speakers, public commenters, and American Sign Language interpreters for making the third HETF meeting a success. She also thanked the HETF subcommittee members for developing their interim recommendations and noted that the four subcommittees will continue to refine their recommendations prior to the next HETF meeting.

Appendix A. Written Public Comments



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Testimony of Victoria Veltri Executive Director, Office of Health Strategy Before the Biden-Harris COVID-19 Health Equity Task Force April 30, 2021

Good afternoon Dr. Marcella Nunez-Smith and members of the Biden-Harris COVID-19 Health Equity Task Force. For the record, I am Victoria Veltri, Executive Director of the State of Connecticut Office of Health Strategy ("OHS"). OHS's mission is to implement comprehensive, data-driven strategies that promote equal access to high-quality health care, control costs and ensure better health for the people of Connecticut.

I appreciate the opportunity to provide comment on significant gaps in race, ethnicity and language (REaL) data collection and our support for your interim recommendations to mandate data collection, harmonization and integrity, in collaboration with marginalized communities and practitioners. While your proposals are tied to the disparities faced particularly by communities of color and disabled individuals during COVID-19 pandemic, I urge you to recommend such data collection across all health care settings on a permanent basis.

OHS' mission is focused on health equity, to reduce health disparities caused by socio-economic factors that intersect in people's lives including race, gender, sexual orientation, gender identity and income. Significant disparities in health status based upon race, ethnicity, language and other factors deprive many Connecticut residents to enjoy good health and wellbeing. The collection of REaL data has been a priority since OHS' inception and aligns with the Governor Lamont's priority of addressing equity. We are grateful for the priority this task force is placing on the collection of this data nationally.

Communities in Connecticut experience serious disparities in clinical and population health outcomes and Black and Brown communities disproportionately suffer from maternal morbidity, asthma, diabetes and COVID-19. Asian American communities and Native Hawaiian and Pacific Islander communities are consolidated in reporting, masking significant disparities. Disparities by disability and insurance status are well documented. In some counties of Connecticut, over 65 languages are spoken. We are no different from other states in this regard and in some cases, our disparities are worsened by substantial economic inequality. Without standard and uniform collection of these data, we cannot understand, identify, and target resources and optimal interventions and solutions to the healthcare disparities that exist.

For the 2021 General Assembly session in Connecticut, OHS has proposed legislation to clarify and standardize race, ethnicity, and language data collection requirements for hospitals and health care providers required to connect to the State's Health Information Exchange (HIE) that includes meaningful

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disaggregation to address longstanding issues of racism and implicit bias in health care delivery and health systems. Our proposal does not mandate that patients must provide this information, but that hospitals and health providers request it and include this data in their Electronic Health Record (EHR) for inclusion in the state's HIE. C.G.S. 17b-59d(b) establishes the goals of the HIE, which includes the ability to 1) support public health reporting, quality improvement, academic research and health care delivery and payment reform through data aggregation and analytics and 2) support population health analytics. Modifying C.G.S. 17b-59e in this manner facilitates consistent data collection. Interoperability, as you noted in your interim recommendations, is a primary area of health information technology efforts nationally and locally. It will not achieve its full promise without the collection of granular REaL, disability status and other information necessary to truly address a patient as a whole or to deliver patient-centered care.

While reporting is critical for discrete public health uses such as vaccine and testing reports, a focus on collection by providers as part of HIE has the promise of a farther reach and interaction with other data sources, such as immunization registries and state agency collection. Health care providers are collecting REaL as required by the Executive Office of the President, Office of Management and Budget (OMB) Standards for the Classification of Federal Data on Race and Ethnicity. OMB defines and utilizes **minimum** standards for collecting such data. The OMB categories are too broad to identify disparities for specific populations in Connecticut. Collection of disaggregated data is critical to understanding a patient's experience and potential medical issues the patient faces.

The presentation provided to this task force last month by Dr. Nadia Islam highlighted these concerns with respect to the Asian American and Native Hawaiian and Pacific Islander Communities. Disaggregation is key to making communities and their unique experiences visible and addressing ongoing structural discrimination. For example, Connecticut has a large Cambodian American community of which many are survivors of the Khmer Rouge. Their experiences, and some of their common health conditions – PTSD, diabetes, hypertension, high-suicide rates, and high early mortality rates – may be very different from other Asian American communities in Connecticut who have their own unique experiences. Importantly, Dr. Islam's slides recognized the disparities in English proficiency among Asian American and Native Hawaiian and Pacific Islander Communities. Such disparities should not be ignored, as one size does NOT fit all.

OHS proposed a change in statewide HIE provider self-reported data collection that included disaggregation among multiple categories, the choice of selection of multiple ethnic or racial designations, and the required collection of primary language data. We know this type of data collection is possible, as evidenced from our office's State Innovation Model's [Community and Clinical Integration Program \(CCIP\)](#), which included the collection of REaL (and other) data to identify and prioritize opportunities to reduce health disparities. We based our standard categories on [deep community engagement](#) across the state and settled on a Connecticut solution. The CCIP categories were derived from American Community Survey data and include sixty-two race and ethnicity categories. The CCIP categories roll up into the OMB categories to reduce administrative complexity.

Hartford Healthcare, and other hospitals and providers that participated in our CCIP program were able to collect the level of REaL data we required through deep engagement with community health workers and

community-based organizations. Some healthcare providers are collecting both what is required by OMB and additional REaL data, disability status and insurance status data, while others are not collecting the data.

We understand that some hospitals and medical practices might have challenges collecting REaL in their EHR systems, especially smaller practices or those using less robust EHR systems. In recognition of that reality, we recommend, as you do as part of interim recommendations, that resources be provided at the federal level to ensure providers are resourced to collect standardized and uniform equity data. Collection means significant training with front line staff and providers on the need for collection and the use of information in addressing a patient's needs, but also in ensuring practitioners address their own biases and improve on their performance. Despite these resource needs, the value of this data collection and its role in identifying and effectively addressing health inequities cannot be overstated. OHS and partners from our health systems, foundations, and others have been working on a roadmap to ensure successful collection of this data. Meeting together over two days, these partners have shown that there is a current path forward, just as you have found, but the need to collect these data must be supported with resources and expectations on the use of the data and improved outcomes.

These data are critical at an aggregate level for analysis. The purpose of REaL data collection is to identify macro-level trends in health disparities by race, ethnicity and language. If we do not collect and report on REaL data in a standard and consistent manner so it can be most helpful to understanding health disparities, we will continue directing resources, developing healthcare policies, interventions, and prevention efforts without the detailed evidence to address structural and systemic racism that is already embedded in our policy making and in healthcare delivery.

We welcome the opportunity to partner with you in supporting your efforts to assure health equity becomes a reality across the United States.

Thank you for providing me the opportunity to deliver our comment today. If you have any questions concerning my testimony, please feel free to ask/contact me at victoria.veltri@ct.gov.

Comments submitted to the COVID-19 Health Equity Task Force April 30, 2021
Chair: Marcella Nunez-Smith, MD

The Pandemic has illustrated one fact; hesitancy is not limited to vaccinations within the Black, Brown and other marginalized communities. The veil of Tuskegee not only impacts the traditional medical model but permeates the Mental and Behavioral Health Systems.

The Health Equity Policy Group is a cohort of Black female Physicians, a Biomedical Research Scientist, Therapists, Life Coaches, Attorneys, Community Engagement and Mental/Behavioral/SUD Treatment Delivery strategists. This group came together to galvanize decades of collective experience to craft policy and implementation strategies addressing COVID-19 in medically underserved community, but as importantly addressing the cultural inequities in the Therapeutic models offered. For the purposes of this commentary, Mental/Behavioral/SUD Treatment are encapsulated under the term "Mental Health".

Predicate:

Coping with the social, political and economic determinants that affect Mental Health is not sourced from an office visit. Said determinants envelop us daily. It is in the news, in the accusing eyes of a store manager, in the micro aggressive comments of a supervisor, in the commercials we watch. It permeates our society. Mental Health is the reflection, the litmus test of who we are as a society and what we value.

Mental Health, like all forms of being in this country, are normed on whiteness. The racial realities of Non-white, and particularly Black people is not systemically taught, recognized, or treated within the traditional Euro-centered Mental Health field. This is because at best the Mental Health field is designed to teach Black bodies to cope with systemic oppression, violence and inequity, while continuing to educate and train practitioners who believe they are incapable of harboring bias and being a tool of a white supremacist system.

The Black community's lack of involvement in America's Mental Health system is not due to stigma, it's due to righteous suspicion. 1) Providers of color are scarce and have been trained within a system branded on Whiteness. 2) These practitioners are discouraged from engaging, sharing, and implementing ancestral cultural healing practices unless they have been appropriated by Whiteness (e.g., yoga, mindfulness) 3) It is designed from a Eurocentric value system of separateness rather than an Afrocentric system of integration.

Value Proposition:

Mental Health for Black and marginalized bodies cannot be remedied by individual diagnosis alone, it is a matter of addressing systemic oppression in and out of the therapy room. Mental Health must shift from an individual symptom-based focus to a societal assessment of root causes if we are to successfully slow the flow of Black/POC clients experiencing distressing levels of disfunction and harm.

Mental Health Professional associations and Governing bodies have the window of opportunity to change the paradigm. The profession and influencers have a responsibility to find, attract, retain, and invite diverse cultures, perspectives, and beliefs in the construction and

implementation of culturally and socially aligned guidelines, ethics, policies, education and standards.

Summary Comments:

There's no diagnosis or modifier for racism. The most minute ethical change is reflexive with little innovation coming from the governing bodies of psychology in this country.

It is necessary to address the impact of micro-invalidation, micro-aggression and similar micro inequities and biases on the mental and overall health of black and marginalized bodies within the societal construct and systems within the society.

If the goal is to equitably address the Mental Health status of Black/POC people, you begin by valuing them in all areas of society in a demonstrable and evident manner.

If not now, when?

We thank you for the opportunity to comment on the topic.

Respectfully Submitted:

Thea Monyéé Winkler, LMFT – Founder MarleyAyo Creative Wellness Consulting – Los Angeles, CA

Amanda E. Ferguson, Pharm.D., RPH Masters candidate McCourt School of Public Policy, Georgetown University – Washington, DC

Jennifer Jones – President/CEO - KyJour International Strategic Business Solutions – Washington, DC

Barbara A. Perkins, President/CEO International Black Women's Public Policy Institute – Atlanta, GA

Margie Scott, JD - Founder, the Law Office of Margie R. Scott, LLC, Licensed in SC & LA

Ruby Long, MD, FACEP – Medicine Medical College of Wisconsin – Milwaukee, WI

Tiffany James – CEO Justice James Consulting – Columbia, SC

Shontreal Cooper, MD - UConn School of Medicine - Farmington, CT

Dorothy Russ, MD JD – The Russ Group, LLC - Jacksonville, FL

Karen A. Robinson, MPA – President/CEO Kinnamon Holdings, LLC - Philadelphia, PA

The Health Equity Policy Group

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May 6, 2021

Marcella Nunez-Smith, MD
Chair
COVID-19 Health Equity Task Force
U.S. Department of Health and Human Services
Office of Minority Health
Tower Oaks Building
1101 Wootton Parkway
Suite 100
Rockville, MD 20852

Dear Dr. Nunez-Smith:

Thank you for your leadership of the COVID-19 Health Equity Task Force. On behalf of the 162,000 members of the American Dental Association (ADA), we are writing to urge you to include an agenda item on how oral health has been affected by the COVID-19 pandemic during the next meeting of the Task Force.

In the spring of 2020, the ADA recommended that dentists close their offices to all but urgent and emergency procedures in order to preserve personal protective equipment (PPE). This affected access to care. For example, the Centers for Medicare and Medicaid Services (CMS) found that, compared to the same time period in 2019, there were 69 percent fewer dental services between March and May 2020 for children enrolled in Medicaid and the Children's Health Insurance Program (CHIP).¹ These children, who come from low-income families and/or have special health care needs, faced oral health disparities before the pandemic. A lack of oral health care during COVID-19 exacerbated these disparities, as small and preventable problems became much more serious. Although the number of dental visits started to increase in July, it is still below prior years' rates.

It is critically important that the Task Force study how COVID-19 affected oral health for both children and adults. More data is needed, including on how race, income, type of dental insurance coverage, and geographic location impacted oral health disparities. Collecting and analyzing this information will help prevent future inequities. Many of the issues discussed during the April 30 meeting of the Task Force in regards to substance use disorders also apply to oral health, including the use of disaggregating data, oversampling among smaller populations in public health surveillance systems, better data collection on social determinants of health, making data more accessible, and more. The ADA looks forward to the Task Force holding an in-depth discussion on oral health similar to the one on substance use disorders.

Thank you again. Should you have questions or want more information, please contact Ms. Roxanne Yaghoubi at yaghoubir@ada.org.

¹ Centers for Medicare and Medicaid Services, "CMS Issues Urgent Call to Action Following Drastic Decline in Care for Children in Medicaid and Children's Health Insurance Program Due to COVID-19 Pandemic," September 23, 2020, <https://www.cms.gov/newsroom/press-releases/cms-issues-urgent-call-action-following-drastic-decline-care-children-medicare-and-childrens-health>.

May 6, 2021
Page 2

Sincerely,

Handwritten signature of Daniel J. Klemmedson in cursive, followed by the text "D.D.S., M.D." in a smaller font.

Daniel J. Klemmedson, D.D.S., M.D.
President

Handwritten signature of Kathleen T. O'Loughlin in cursive, followed by the text "D.M.D., M.P.H." in a smaller font.

Kathleen T. O'Loughlin, D.M.D., M.P.H.
Executive Director

DJK:KTO:ry



May 6, 2021

COVID-19 Health Equity Task Force
Office of Minority Health
US Department of Health and Human Services
Tower Oaks Building
1101 Wootton Parkway, Suite 100
Rockville, MD 20852

Via Email: COVID19HETF@hhs.gov

Dear Dr. Nunez-Smith and Task Force Members,

The National Association of Chain Drug Stores (NACDS) would like to extend our tremendous appreciation to the Task Force for your leadership. We applaud your work to put forth interim recommendations aimed at advancing health equity in the context of addressing the serious behavioral health impact of COVID-19. The urgency and widespread nature of the COVID-19 pandemic, paired with increasing behavioral health challenges, require innovative solutions that leverage the unique expertise and accessibility of the entire healthcare continuum, especially those on the frontlines of care, such as community pharmacies. Community pharmacies share the Task Force's goals to advance equity and improve access to behavioral health interventions especially in marginalized communities, in addition to improving community engagement. NACDS urges the Task Force to leverage the reach, trust, and clinical expertise of the nation's 60,000 community pharmacies to help advance equity and alleviate widespread access gaps to help support and connect people with the behavioral health help they need in their community. Specifically, NACDS offers concepts to supplement the Task Force's interim recommendations starting on page 6 of this document.

NACDS represents traditional drug stores, supermarkets and mass merchants with pharmacies. Chains operate nearly 40,000 pharmacies, and NACDS' 80 chain member companies include regional chains, with a minimum of four stores, and national companies. Chains employ nearly 3 million individuals, including 155,000 pharmacists. They fill over 3 billion prescriptions yearly, and help patients use medicines correctly and safely, while offering innovative services that improve patient health and healthcare affordability. NACDS members also include more than 900 supplier partners and over 70 international members representing 21 countries. Please visit nacds.org.

Just as pharmacies have supported their communities on the frontlines of the COVID-19 pandemic, pharmacies are increasingly helping to bridge access gaps for behavioral health needs, and for example, have directly battled the opioid epidemic for years. In fact, pharmacist involvement in opioid use disorder care helps improve access and outcomes, while reducing the risk of relapse.^{1,2} A recent article by Pringle, Aruru, and Cochran³ noted that by allowing community pharmacists to be more involved in direct patient care, community pharmacists can help eliminate gaps and barriers in treatment and increase access to naloxone and medication assisted therapy (MAT), now known as Medications for Opioid Use Disorder (MOUD), as well as play a critical role in implementing strategies to help reduce population opioid use disorder risk.

¹ DiPaula, B.A. & Menachery, E. (Mar/Apr 2015). Physician-pharmacist collaborative care model for buprenorphine-maintained opioid-dependent patients, *Journal of the American Pharmacists Association*, 55(2), 187-192, available at: <https://www.ncbi.nlm.nih.gov/pubmed/25749264>

² Raisch, W. (2002). Opioid Dependence Treatment, Including Buprenorphine/Naloxone, *Pharmacology & Pharmacy*, 36(2), 312-321.

³ Pringle JL, Aruru M, Cochran J, Role of pharmacists in the Opioid Use Disorder (OUD) crisis, *Research in Social & Administrative Pharmacy* (2018), doi: <https://doi.org/10.1016/j.sapharm.2018.11.005>.

DISCUSSION

I. Pharmacies Provide Local, Trusted Access to Help Support Behavioral Health Interventions, Including Treatment and Recovery for Substance and Opioid Use Disorders. Community pharmacies provide unique and necessary local access to help effectively address widespread care availability gaps for those suffering from opioid and other substance use disorders and other behavioral health challenges. In fact, about 90% of Americans live within 5 miles of a community pharmacy. Further, new access points to behavioral health support in communities are essential, especially considering that, for example, only a mere 11% of adults with substance use disorders are receiving treatment.⁴ Promisingly, a recent study examined the distribution of community pharmacies across a state relative to the location of substance abuse treatment centers and opioid-related overdoses to explore the potential for community pharmacies to play a greater role in opioid abuse prevention and treatment.⁵ The study found that community pharmacies were more prevalent than substance abuse treatment centers – especially in rural counties – which could make them an important partner in MOUD and prevention efforts in underserved areas.⁶

Beyond their accessibility, pharmacies across the country are increasingly providing a wide range of services geared towards improving access to behavioral health interventions, including preventing, identifying, and managing drug misuse and abuse.⁷ On a daily basis, pharmacists collaborate with other members of the healthcare team to help ensure the legitimacy of all prescriptions and proper and safe use of controlled substances; and pharmacists initiate and dispense naloxone to increase access to these drugs and help prevent fatal overdoses.⁸ For example, according to research published in the Journal of the American Medical Association, an Ohio law permitting pharmacists to dispense naloxone without a prescription was associated with a 2,328% increase in naloxone orders.⁹ Pharmacists also provide counseling and patient education including safe opioid disposal, leverage tools such as prescription drug monitoring programs to screen patients for inappropriate drug use, and intervene where possible, while balancing their responsibilities as providers of patient care.^{10,11} Additionally, research is increasingly pointing to the important role of pharmacists in Screening, Brief Intervention and Referral to Treatment (SBIRT), which is a model supported by the Substance Abuse and Mental Health Services Administration (SAMHSA). Early evidence indicates that risk for opioid medication misuse can be identified in rural and urban community pharmacies – and consumers are generally open to screenings and discussions with pharmacists about potentially problematic usage.¹²

Further, pharmacies can provide a broad-sweeping range of pertinent clinical interventions to reduce gaps, improve access, and advance equity in behavioral health support for the public. **Examples are included below:**

- **Screening – Brief Intervention – Referral to Treatment (SBIRT).** Given the strong ties of community pharmacies in neighborhoods across the country, work is underway to implement collaborative, community-based SBIRT models where patients are first screened in the comfort and convenience of their local, familiar, community pharmacy and then receive intervention and linkage to care from the pharmacists they know and trust. Especially at the point of dispensing, pharmacists are uniquely positioned to offer SBIRT to at-risk patients. Through a screening process, pharmacists identify those at risk of opioid or other substance use disorders, provide brief counseling and motivational interviewing, as well as linkage to care through warm handoffs with

⁴ Substance Abuse and Mental Health Services Administration (SAMHSA). (2017). Key substance use and mental health indicators in the United States: Results from the 2016 National Survey on Drug Use and Health (HHS Publication No. SMA 17-5044, NSDUH Series H-52).

⁵ Look, K., Kile, M., Morgan, K. et al. (2018). Community Pharmacies as Access Points for Addiction Treatment. *Research in Social and Administrative Pharmacy*, S1551-7411(18)30217-1. <https://www.ncbi.nlm.nih.gov/pubmed/29909934>

⁶ Ibid.

⁷ Reynolds V, et al. The Role of Pharmacists in the Opioid Epidemic: An Examination of Pharmacist-Focused Initiatives Across the United States and North Carolina. *North Carolina Medical Journal*. May-June 2017 vol. 78 no. 3 202-205. <https://www.ncbi.nlm.nih.gov/pubmed/28576963>

⁸ The National Alliance of State Pharmacy Associations. (January 2019). Pharmacist Prescribing Naloxone. <https://naspa.us/resource/naloxone-access-community-pharmacies>

⁹ Gangal NS, Hincapie AL, Jandarov R, et al. Association Between a State Law Allowing Pharmacists to Dispense Naloxone Without a Prescription and Naloxone Dispensing Rates. *JAMA Netw Open*. 2020;3(1):e1920310. doi:10.1001/jamanetworkopen.2019.20310

¹⁰ Winstanley, EL. et al. The development and feasibility of a pharmacy-delivered opioid intervention in the emergency department. *Journal of the American Pharmacists Association*, Volume 57, Issue 2, S87 - S91. <https://www.ncbi.nlm.nih.gov/pubmed/28292506>

¹¹ Riley TB, Alemagno S. Pharmacist utilization of prescription opioid misuse interventions: Acceptability among pharmacists and patients. *Research in Social and Administrative Pharmacy*. Volume 15, Issue 8, August 2019, Pages 986-991. <https://www.ncbi.nlm.nih.gov/pubmed/30665825>

¹² Cochran, G., Rubinstein, H., Bacci, J. et al. (2016). Screening Community Pharmacy Patients for Risk of Prescription Opioid Misuse. *Journal of Addiction Medicine*, 9(5) 411-416. <https://www.ncbi.nlm.nih.gov/pubmed/26291546>

local treatment and recovery providers. This model can increase access to screening and education, as well as help to eliminate gaps in linking patients to treatment through local coordination. Currently, pharmacy-based SBIRT services are being rolled out in Pennsylvania, Virginia, and Ohio. The Virginia Medicaid program, which supports coverage for pharmacist-provided SBIRT, is a leading example.

- **Medications for Opioid Use Disorder (MOUD), also known as Medication-Assisted Treatment (MAT).** In certain states, such as Ohio, pharmacists can administer naltrexone as part of a MAT or MOUD plan for patients. There are other notable pilot programs in Kentucky and Maryland. The Kentucky project allows pharmacists to manage patients on naltrexone¹³ and the Maryland program offers buprenorphine through a single pharmacy connected to the Health Department.¹⁴ Further, in Kentucky, the Board of Pharmacy has authorized pharmacists to execute clinical protocols and initiate the dispensing of medications for several conditions, including opioid use disorder pursuant to recommendations by the American Society of Addiction Medicine¹⁵.

Another leading example is a Rhode Island MAT program, funded by a \$1.6 million NIDA grant. Under this initiative, the Rhode Island Hospital is conducting a pilot program¹⁶ involving six pharmacies working with 125 patients to manage their MAT. In the pilot, patients receive their initial MAT prescription from a physician. After the physician determines a patient is stable on their medication, a pharmacist working under a collaborative practice agreement takes over the patient's care. Visiting the pharmacy once or twice a week, patients meet in a private room with their pharmacist. The pharmacist places a swab under the patient's tongue for several minutes, which will be sent to a lab for analysis to indicate whether that patient has taken the full dose of their prescribed medication or used any illicit substances. With that information, pharmacists counsel patients about recovery goals, struggles, and successes. They also employ motivational interviewing, a counseling technique that helps patients overcome ambivalence and make behavioral changes. Most patients enrolled in the pilot are expected to take buprenorphine, but patients also have the option of a once-a-month injection of naltrexone.

- **Naloxone.** Currently, all 50 states authorize pharmacists to dispense naloxone. However, barriers remain including the need for standing orders or protocols, and patient copays which limit access and uptake.^{17,18,19} Unfortunately, the CDC reports that only 1 naloxone prescription is dispensed for every 70 high risk opioid prescriptions, and rural areas are even less likely to have naloxone access.²⁰ Despite barriers, pharmacies and pharmacists continue to help advance access to naloxone and promote uptake.
- **Screening for Social Determinants of Health.** As accessible and trusted healthcare professionals, evidence shows pharmacists are effective in helping to screen for social determinants of health and can provide linkage to community resources.²¹ As an example, one initiative that leveraged community pharmacists to screen for social determinants of health resulted in 9,802 successful assessments from 2,162 pharmacies conducted between November 15, 2019, and December 31, 2019. The patients included had chronic conditions such as COPD, depression, diabetes, hyperlipidemia, and hypertension. Findings of this project showed that the most prevalent SDOH reported by patients to the pharmacists were food insecurity, social isolation, and transportation challenges. Importantly, 12.5% reported problems with their food supply over the past 12

¹³ [https://www.pharmacytoday.org/article/S1042-0991\(17\)31120-9/fulltext](https://www.pharmacytoday.org/article/S1042-0991(17)31120-9/fulltext)

¹⁴ <https://www.bostonglobe.com/metro/2019/03/12/getting-addiction-care-pharmacy/m1mceVILRX1W9X3WdeOP/story.html>

¹⁵ Kentucky Board of Pharmacy. Board Approved Protocols. <https://pharmacy.ky.gov/Pages/Board-Approved-Protocols.aspx>

¹⁶ Freyer F. In Rhode Island, Some Get Addiction Care at the Pharmacy. Boston Globe. March 2019. <https://www.bostonglobe.com/metro/2019/03/12/getting-addiction-care-pharmacy/m1mceVILRX1W9X3WdeOP/story.html>

¹⁷ Seiler N, Horton K, et al. Medicaid Reimbursement for Take-Home Naloxone: A toolkit for Advocates. GWU Milken Institute School of Public Health. 2015. https://prescribeprevent.org/wp2015/wp-content/uploads/naloxone_medicaid_report_gwu.pdf

¹⁸ Gorman A. Pharmacists hesitant to dispense lifesaving overdose drug naloxone. Modern Healthcare. January 2018.

¹⁹ <https://www.modernhealthcare.com/article/20180106/NEWS/180109948/pharmacists-hesitant-to-dispense-lifesaving-overdose-drug-naloxone>

²⁰ Walley AY. Naloxone Dispensing via Retail Pharmacies. Presented at Dec 2018 FDA Meeting. <https://www.fda.gov/media/121183/download>

²¹ Vital Signs: Life-Saving Naloxone from Pharmacies. Centers for Disease Control and Prevention. August 2019. <https://www.cdc.gov/vitalsigns/naloxone/index.html>

²² AMA J Ethics. 2021;23(2):E117-126. doi: 10.1001/amajethics.2021.117.

months, 11.2% reported difficulties in finding transportation, and 18% reported experiencing loneliness or social isolation.²²

- **Screening for Depression and Anxiety:** Those with opioid use disorders, for example, are more likely to have anxiety and depression.²³ Research indicates pharmacists can help improve screening for mental health conditions and help provide linkage to care. As an example, one study included 3,726 patients screened for depression by pharmacists. Of the patients who completed the PHQ-9, approximately 25% met the criteria for consideration of diagnosis and were referred to their physician. Five patients presented with suicidal thoughts and were referred for urgent treatment. Approximately 60% of patients with a positive PHQ-9 had initiated or modified treatment at the time of follow-up. The author concluded that a screening program for depression can be successfully developed and implemented in the community pharmacy setting. Using the PHQ, pharmacists were able to quickly identify undiagnosed patients with symptoms of depression. The majority of patients with a positive screening had initiated or modified treatment at the time of follow-up.²⁴ A similar model implemented in Australia also demonstrated feasibility and effectiveness.²⁵
- **Mental Health First Aid:** Pharmacists are increasingly being trained in mental health first aid. Research to date has demonstrated effectiveness and positive public perceptions.^{26,27,28}

Wraparound Health and Wellness Support – Examples:

- **Point-of-Care Testing for Chronic Conditions, HIV, Hepatitis C and more.** Pharmacies are increasingly providing a wide range of point-of-care tests including COVID-19, flu, strep throat, A1c screening, and more. Importantly, pharmacies throughout the country have also partnered with local health departments to develop HIV and hepatitis C pharmacy-based screening programs that include linkage to care if a test is positive.^{29,30} For example, a partnership between the Virginia Department of Public Health and community pharmacies provided HIV tests to more than 3,600 individuals over 2 years. Approximately half of these patients had never been tested for HIV before, and those who tested positive were linked to appropriate care with the assistance of a pharmacist.³¹ The importance of pharmacy and public health partnerships is further supported by the CDC and their belief that these partnerships “can drive team-based care and community-clinical links by connecting organizations and individuals who have a common goal to improve population health.”³²
- **Tobacco Cessation:** More than 80% of patients dependent on opioids also smoke cigarettes.³³ CDC, CMS, and other public health leaders have noted the robust ability for pharmacists to play an important role in smoking

²² Markus D, Dean S. Tackling Social Determinants of Health by Leveraging Community Pharmacies in a National, Scalable Model. Presented at: PQA 2020 Annual Meeting; May 13-15, 2020.

²³ <https://pcssnow.org/resource/opioid-addiction-psychiatric-comorbidities/>

²⁴ Rosser S, Frede S, Conrad WF, Heaton PC. Development, implementation, and evaluation of a pharmacist-conducted screening program for depression. *J Am Pharm Assoc*. 2013 Jan-Feb;53(1):22-9. doi: 10.1331/JAPhA.2013.11176. <https://www.ncbi.nlm.nih.gov/pubmed/23636152>

²⁵ O'Reilly CL, Wong E, Chen TF. A feasibility study of community pharmacists performing depression screening services. *Res Social Adm Pharm*. 2015 May-Jun;11(3):364-81. <https://www.ncbi.nlm.nih.gov/pubmed/25438728>

²⁶ Witry MJ, Fadare O, Pudlo A. Pharmacy professionals' preparedness to use Mental Health First Aid (MHFA) behaviors. *Pharm Pract (Granada)*. 2020 Oct-Dec;18(4):2102. doi: 10.18549/PharmPract.2020.4.2102. Epub 2020 Nov 14. PMID: 33294061; PMCID: PMC7699831.

²⁷ Community Pharmacists as Partners in Reducing Suicide Risk

Cortney M. Mospan, Chris Gillette, Jerry McKee, Stephanie S. Daniel

The Journal of the American Board of Family Medicine Nov 2019, 32 (6) 763-767; DOI: 10.3122/jabfm.2019.06.190021

²⁸ Dollar KJ, Ruisinger JF, Graham EE, Prohaska ES, Melton BL. Public awareness of Mental Health First Aid and perception of community pharmacists as Mental Health First Aid providers. *J Am Pharm Assoc* (2003). 2020 Sep-Oct;60(5S):S93-S97.e1. doi: 10.1016/j.japh.2020.01.017. Epub 2020 Mar 2. PMID: 32139284.

²⁹ Hoth A, Shafer C, et al. Iowa TelePREP: A Public-Health-Partnered Telehealth Model for HIV Pre-Exposure Prophylaxis (PrEP) Delivery in a Rural State. *Sexually Transmitted Diseases*. May 2019. <https://www.ncbi.nlm.nih.gov/pubmed/31157732>

³⁰ Dong BJ, et al. Pharmacists performing hepatitis C antibody point-of-care screening in a community pharmacy: A pilot project. *Journal of the American Pharmacists Association*. Volume 57, Issue 4, July–August 2017, Pages 510-515. <https://www.sciencedirect.com/science/article/pii/S1544319117306660?via%3Dihub>

³¹ Collin B, et al. The “No Wrong Door” Approach to HIV Testing: Results From a Statewide Retail Pharmacy–Based HIV Testing Program in Virginia, 2014–2016. 2018. *Public Health Rep*. 2018;133(2):345-425. <https://journals.sagepub.com/doi/full/10.1177/0033354918801026>

³² <https://www.cdc.gov/dhsp/pubs/docs/engaging-pharmacy-partners-guide.pdf>

³³ Kalman D, Morissette SB, George TP. Co-morbidity of smoking in patients with psychiatric and substance use disorders. *Am J Addict*. 2005;14(2):106-123. doi:10.1080/10550490590924728

cessation.³⁴ These acknowledgements are underpinned by a wealth of research demonstrating the clinical value of pharmacist-led smoking cessation.³⁵ The evidence includes a comprehensive umbrella review on preventive care³⁶ and a 2020 report from the U.S. Surgeon General that explicitly acknowledges pharmacists' ability to help patients stop smoking.³⁷ A handful of states authorize pharmacies to play an elevated role in initiation of prescription and over the counter products to support patients in smoking cessation. In fact, Colorado, Idaho, Indiana, and New Mexico authorize pharmacists to initiate all medications approved by the U.S. Food and Drug Administration for smoking cessation.³⁸ As an example, New Mexico specifically allows for autonomous tobacco cessation aid prescribing by pharmacists, and for more than a decade, pharmacists have done this with evidence indicating pharmacist-provided tobacco cessation is highly efficacious.³⁹

- **Immunizations:** The ability for pharmacies to expand access to vaccination and improve vaccination rates has been well documented.^{40,41,42,43} Pharmacies help expand access to vaccination broadly to help drive broader public health goals and improve health outcomes. This was further emphasized during the current COVID-19 pandemic as the federal government called on pharmacists, by authorizing pharmacists to order and administer COVID and childhood vaccines, to expand access to such an essential service throughout the nation.
- **HIV Pre-Exposure Prophylaxis (PrEP) and Post-Exposure Prophylaxis (PEP):** These critical medications for HIV/AIDS prevention represent low risk, high value opportunities for pharmacists to better serve at-risk populations and expand the use of this important therapy. The use of PrEP has increased dramatically since 2012. However, the CDC has estimated that while 1.2 million people in the US could benefit from HIV prevention like PrEP, there were only 77,120 PrEP users in the US in 2016.⁴⁴ This enormous gap in care can be filled by supporting and expanding the ability of community pharmacists to provide these interventions. These medications can be difficult for patients to obtain for many reasons, as individuals who need these medications may not have access to or be able to afford a visit to a provider or they may be concerned about stigma. To help combat these challenges, more and more states are looking to pharmacists to help fill care gaps. For example, states including New Mexico, Iowa, and Washington, have piloted studies that show pharmacist-run, or pharmacist-involved, PrEP clinics are an effective way to increase uptake of the medication, which can then lead

³⁴ Centers for Disease Control and Prevention, Pharmacists: Help Your Patients Quit Smoking, April 22, 2019. <https://www.cdc.gov/tobacco/campaign/tips/partners/health/pharmacist/index.html>

Department of Health and Human Services, Centers for Medicare & Medicaid Services; CMCS Informational Bulletin, State Flexibility to Facilitate Timely Access to Drug Therapy by Expanding the Scope of Pharmacy Practice using Collaborative Practice Agreements, Standing Orders or Other Predetermined Protocols. <https://www.medicare.gov/federal-policy-guidance/downloads/cib011717.pdf>

Tobacco Control Network, Access to Tobacco Cessation Medication Through Pharmacists, Feb 8, 2017, available at <http://www.astho.org/Prevention/Tobacco/Tobacco-Cessation-Via-Pharmacists/>

³⁵ Patel AR, Breck AB, Law MR. The impact of pharmacy-based immunization services on the likelihood of immunization in the United States. *Journal of the American Pharmacists Association*. August 2018. [https://www.japha.org/article/S1544-3191\(18\)30231-0/pdf](https://www.japha.org/article/S1544-3191(18)30231-0/pdf)

³⁶ San-Juan-Rodriguez A, Newman TV, Hernandez I, et al. Impact of community pharmacist-provided preventive services on clinical, utilization, and economic outcomes: An umbrella review. *Preventive Medicine*. 2018. <https://www.ncbi.nlm.nih.gov/pubmed/30145351>

³⁷ <https://www.hhs.gov/sites/default/files/2020-cessation-sgr-full-report.pdf>

³⁸ Adams AJ, Hudmon KS. Pharmacist prescriptive authority for smoking cessation medications in the United States. *J Am Pharm Assoc* (2003). 2018 May-Jun;58(3):253-257. doi: 10.1016/j.japh.2017.12.015. Epub 2018 Feb 14. PMID: 29426612.

³⁹ https://www.americanbar.org/groups/health_law/publications/aba_health_esource/2018-2019/july2019/tobacco/

⁴⁰ Sokolow LZ, Patel A, Koonin LM, Graitcer SB. Scripted Surge Pharmacy Pandemic Exercise: Testing Vaccine Administration and Antiviral Dispensing. *Health Security*. 2018 Jul/Aug;16(4):262-273. <https://www.ncbi.nlm.nih.gov/pubmed/30133375>

⁴¹ Chowell G, Miller M, Viboud C. Seasonal influenza in the United States, France, and Australia: Transmission and prospects for control. *Epidemiology and Infection*. July 2007. <https://www.ncbi.nlm.nih.gov/pubmed/17634159>

⁴² Aronson JK, Brassey J, Mahtani KR. Oxford University Center for Evidence Based Medicine. April 2020. <https://www.cebm.net/covid-19/when-will-it-be-over-an-introduction-to-viral-reproduction-numbers-r0-and-re/>

⁴³ del Rio C, Malani PN. COVID-19—New Insights on a Rapidly Changing Epidemic. *JAMA*. February 2020. <https://jamanetwork.com/journals/jama/fullarticle/2762510>

⁴⁴ Sanche S, Lin YT, Xu C, Romero-Severson E, Hengartner N, Ke R. High contagiousness and rapid spread of severe acute respiratory syndrome coronavirus 2. *Emerg Infect Dis*. 2020. https://wwwnc.cdc.gov/eid/article/26/7/20-0282_article

Ying Liu, Albert A Gayle, Annelies Wilder-Smith, Joacim Rocklöv. *Journal of Travel Medicine*. March 2020. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7074654/>

⁴¹ Bartsch SM et al. Epidemiologic and economic impact of pharmacies as vaccination locations during an influenza epidemic. *Vaccine*. November 2018. <https://www.ncbi.nlm.nih.gov/pubmed/30340884>

⁴² Goad JA, Taitel MS, Fensterheim LE, Cannon AE. Vaccinations administered during off-clinic hours at a national community pharmacy: implications for increasing patient access and convenience. *Ann Fam Med*. 2013;11(5):429-436. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3767711/>

⁴³ Schwerzmann J, Graitcer SB, Jester B, Krahl D, Jernigan D, Bridges CB, Miller J. Evaluating the Impact of Pharmacies on Pandemic Influenza Vaccine Administration. *Disaster Med Public Health Prep*. 2017 Oct;11(5):587-593. <https://www.ncbi.nlm.nih.gov/pubmed/28219461>

⁴⁴ Mapping PrEP: First Ever Data on PrEP Users Across the US. AIDSvu- Emory University Rollins School of Public Health and Gilead Sciences. <https://aidsvu.org/prep/>

to decreased HIV transmission.^{45,46,47} In 2019, California enacted a law granting pharmacists authority to initiate PrEP and PEP.⁴⁸ To improve access to emergency PEP, New York allows pharmacists, through a non-specific patient order, to provide 7 days of PEP to patients without a prescription.⁴⁹ Given that the medication is more effective if started within 72 hours, access to convenient, local care options is even more critical.

Please see Appendix A for additional literature examples.

II. Key Opportunities to Leverage Pharmacies within the Task Force's Interim Recommendations

NACDS supports and applauds the Task Force's work to put forth interim recommendations aimed at advancing health equity in the context of addressing the serious behavioral health impact of COVID-19. As described above, pharmacists can make meaningful impacts on advancing equity and access for behavioral health interventions across a wide range of clinical services, including for substance and opioid use disorders and other wraparound health and wellness support. However, despite a myriad of evidence demonstrating the benefits and effectiveness of pharmacy-based care, pharmacists have been vastly underutilized to date in tackling behavioral health.

Therefore, to supplement the Task Force's robust interim recommendations and further advance actionable, local recommendations to improve equity and access for behavioral health support, NACDS recommends, for example, the following opportunities to leverage pharmacies to advance the Task Force's goals. NACDS suggestions are outlined for consideration in [blue text](#).

- The federal government should evaluate, [and consider strategies to make permanent](#), policy changes during the pandemic that expanded access to mental health care and substance use disorder treatment, [in addition to policies that expanded access to care and equity broadly. For example, actions taken under the PREP Act that expanded access to COVID-19 vaccines, testing, and childhood catch-up vaccines at pharmacies.](#)
- Enact health insurance payment policies for substance abuse [screening, linkage to care, and treatment, in addition to all wraparound preventive services such as HIV and hepatitis C screening, including when provided in community-based settings such as pharmacies by pharmacists and their staff.](#)
- Declare healthcare access and coverage a human right. Align federal policies and funding to secure this right, [including removal of undue state scope of practice barriers that impede community care delivery, and increase funding support for all relevant providers of care and settings, including pharmacists and pharmacies.](#)
- Increase immediate funding to Medicaid and Medicare providers, [and create new funding pathways for other relevant healthcare providers such as pharmacists](#), in marginalized populations along the pathways of licensed health care professionals' reimbursement rates, peer support programs, and social determinants of mental health.
- Programs to treat more severe mental illness should be operated and distributed through federally funded health centers and rural health clinics, [community pharmacies](#), primary care and pediatricians' offices, and schools, to increase support for screening, education, and referrals.
- Pilot and fund harm-reduction initiatives, with community involvement and health equity in mind, [leveraging all applicable stakeholders including community pharmacies.](#)
- Massive scaling up of the federal financial investment into substance use treatment, prevention, and harm reduction services and pass legislation like the CARES Act of 2020; [include funding to expand access to screening, support, linkage to care, referrals, and relevant wraparound support provided by all relevant providers and settings, including pharmacists and pharmacies.](#)
- Invest federal funding in the development of racially, ethnically, and culturally diverse mental health workforce that includes a full range of licensed health care professionals, [including community pharmacists](#), and

⁴⁵ Ryan K, Lewis J, Sanchez D, et al. The Next Step in PrEP: Evaluating Outcomes of a Pharmacist-Run HIV Pre-Exposure Prophylaxis (PrEP) Clinic. ID Week 2018 Poster Abstract Session. Oct 2018. <https://idsa.confex.com/idsa/2018/webprogram/Paper72194.html>

⁴⁶ Hoth A, Shafer C, et al. Iowa TelePrEP: A Public-Health-Partnered Telehealth Model for HIV Pre-Exposure Prophylaxis (PrEP) Delivery in a Rural State. Sexually Transmitted Diseases. May 2019. <https://www.ncbi.nlm.nih.gov/pubmed/31157732>

⁴⁷ Tung EL, Thomas A. Implementation of a community pharmacy-based pre-exposure prophylaxis service: a novel model for pre-exposure prophylaxis care. Sex Health. Nov 2018. <https://www.ncbi.nlm.nih.gov/pubmed/30401342>

⁴⁸ Kazi DS. PrEParing to End the HIV Epidemic — California's Route as a Road Map for the United States. December 26, 2019. N Engl J Med 2019; 381:2489-2491. DOI: 10.1056/NEJMp1912293.

⁴⁹ New York State Education Department, Pharmacy Unit. §6801. Definition of practice of pharmacy. <http://www.op.nysed.gov/prof/pharm/article137.htm>

acknowledge structural urbanism and establish programs, policies, and funding to support thriving rural community that includes [pharmacies](#), clinics, treatment centers, rural hospitals, and mobile health vans to transport licensed health care professionals where needed.

- Encourage states to adopt DEA guidance authorizing physicians to start buprenorphine treatment via telephone evaluation, [and expand opportunities for other qualified health professionals to initiate buprenorphine treatment, including pharmacists.](#)
- The federal government should issue guidelines and provide resources to implement widespread mental health, substance use disorder and interpersonal violence screening, [across all applicable healthcare settings, including pharmacies, and](#) including screening of children, healthcare workers, LGBTQ+, native and tribal populations, remote and or rural communities, people with disabilities, those living in congregate settings (including skilled nursing facilities, group homes, rehabilitation facilities, intermediate care facilities, homeless shelters, state hospitals, jails, and prisons), and the elderly.
- The federal government should convene an interagency group, [representing all relevant stakeholders including pharmacies,](#) that promotes and aligns the collection, reporting, and sharing of data to understand and drive responses to prevent and treat substance use disorders and support the health and well-being of people living with mental health or substance use disorders.
- The federal government should evaluate the efficacy and accessibility of expanded telehealth services in the context of the pandemic, [across all healthcare providers, including pharmacists.](#)
- Address barriers and disruptions to mental health services during the COVID-19 pandemic through telehealth and with the expansion of healthcare coverage and access, [across applicable settings and providers including pharmacies and pharmacists,](#) amongst others.
- Federal government to increase funding for suicide interventions through faith-based and community organizations, [across all relevant settings and providers including pharmacies and pharmacists.](#)

III. CONCLUSION

Pharmacies and pharmacists share the goal of the Task Force to address ongoing behavioral healthcare challenges while improving equity, health, and wellness broadly for marginalized communities. By utilizing strong community-based partnerships and relationships with local advocates, public health, physicians and behavioral health specialists, peer supports, and others, pharmacies across the nation can help play a vital role in reaching this goal. Pharmacists are well positioned to collaborate at the federal and local levels to help eliminate gaps in access and treatment, deliver seamless and coordinated care, and ultimately ensure Americans receive the care they need and deserve. Furthermore, the numerous locations and expanded hours of pharmacies provide the community with convenient and accessible care options to receive essential care. Pharmacies can and are utilizing the lessons learned and lived experiences of advancing equitable healthcare delivery during the COVID-19 pandemic to help address other critical public health crises and are a valuable resource in the campaign to address behavioral health in minority groups.

NACDS applauds the hard work of the Task Force to advance interim recommendations presented at the April 30th meeting, and we appreciate the opportunity to recommend strategies that leverage pharmacies to help strengthen the recommendations. We welcome the opportunity to be a partner and resource as these recommendations are finalized and implemented. We appreciate your ongoing leadership and dedication to advance health equity for the nation.

Sincerely,



Steven C. Anderson, FASAE, CAE, IOM
President and Chief Executive Officer National Association of Chain Drug Stores

Appendix A. Examples of Pharmacist Impacts on Behavioral Health & Underserved Communities	
Community pharmacists have the capacity to identify patients at risk for misuse of opioid medications . Of the 164 patients who completed the survey, 14.3% screened positive for prescription opioid misuse risk, 7.3% for illicit drug use, 21.4% for hazardous alcohol use, 25.8% for depression, and 17.1% for post-traumatic stress disorder (PTSD).	Cochran G, Rubinstein J, Bacci JL, Ylioja T, Tarter R. Screening Community Pharmacy Patients for Risk of Prescription Opioid Misuse. J Addict Med. 2015 Sep-Oct;9(5):411-6. https://www.ncbi.nlm.nih.gov/pubmed/26291546
In Rhode Island, a grant from the National Institute on Drug Abuse is being used to allow patients to receive addiction care at a community pharmacy . Through this program, patients receive their initial prescription from a physician and, when stable, a pharmacist will take over their care, including conducting toxicology swabs to determine adherence and providing motivational counseling. Participants report increased convenience and comfort with receiving addiction care at their local pharmacy.	Freyer F. In Rhode Island, Some Get Addiction Care at the Pharmacy. Boston Globe. March 2019. https://www.bostonglobe.com/metro/2019/03/12/getting-addiction-care-pharmacy/m1mceVILRX1W9X3WdeOP/story.html
In this pharmacist-physician collaborative care model, pharmacists conducted intake assessments and follow-up appointments with patients taking buprenorphine in order to further expand access to treatment . This program demonstrated 100% 6-month retention rates and 73% 12-month retention rates with an estimated cost savings of \$22,000 . Data from this pilot was then used to develop a permanent program utilizing this model.	DiPaula BA, Menachery E. Physician-pharmacist collaborative care model for buprenorphine-maintained opioid-dependent patients. J Am Pharm Assoc (2003). 2015 Mar-Apr;55(2):187-92. https://www.ncbi.nlm.nih.gov/pubmed/25749264
Twenty-six percent of individuals (n = 107) receiving opioid prescriptions were identified as at some risk of misuse and 30% at risk of an accidental overdose . Participating pharmacists preferred the value of having an objective measurement of potential of opioid misuse , to relying only on professional judgment. They also reported the value of the toolkit elements in enhancing conversations with patients.	Strand MA, Eukel H, Burck S. Moving opioid misuse prevention upstream: A pilot study of community pharmacists screening for opioid misuse risk. Res Social Adm Pharm. 2019 Aug;15(8):1032-1036. https://www.ncbi.nlm.nih.gov/pubmed/30031696
This study found large and statistically significant decreases for almost every measure of substance use in patients who received SBIRT method screening services, including decreases in alcohol use, heavy drinking, and illicit drug use. Greater intervention intensity was also associated with larger decrease in substance use.	Aldridge A, Linford R, Bray J. Substance use outcomes of patients served by a large US implementation of Screening, Brief Intervention and Referral to Treatment (SBIRT). Addiction. 2017 Feb;112 Suppl 2:43-53. https://www.ncbi.nlm.nih.gov/pubmed/28074561
Pharmacy-based immunization services increased the likelihood of immunization for influenza and pneumococcal diseases, resulting in millions of additional immunizations in the United States. Five years after national implementation, it is estimated that 6.2 million additional influenza immunizations and 3.5 million additional pneumococcal immunizations are attributable to pharmacy-delivered immunization services each year	Patel AR, Breck AB, Law MR. The impact of pharmacy-based immunization services on the likelihood of immunization in the United States. Journal of the American Pharmacists Association. August 2018. https://www.iapha.org/article/S1544-3191(18)30231-0/pdf

<p>Pharmacist-provided MTM can improve chronic disease intermediate outcomes for medically underserved patients in FQHCs. This pilot study displayed improvement in diabetes and hypertension clinical markers associated with pharmacist provision of MTM. A1c goal achievement occurred in 52.84% of patients and hypertension control was reported in 65.21%. Pharmacists identified and resolved more than 1400 medication-related problems and addressed multiple adverse drug event issues.</p>	<p>Rodis JL, et al. Improving Chronic Disease Outcomes Through Medication Therapy Management in Federally Qualified Health Centers. Journal of Primary Care & Community Health. 2017. https://www.ncbi.nlm.nih.gov/pubmed/28381095</p>
<p>A large proportion of adults being vaccinated receive their vaccines during evening, weekend, and holiday hours at the pharmacy, when traditional vaccine providers are likely unavailable. Younger, working-aged, healthy adults, in particular, a variety of immunizations during off-clinic hours. With the low rates of adult and adolescent vaccination in the United States, community pharmacies are creating new opportunities for vaccination that expand access and convenience.</p>	<p>Goad JA, et al. Vaccinations Administered During Off-Clinic Hours at a National Community Pharmacy: Implications for Increasing Patient Access and Convenience. Annals of Family Medicine. September 2013. https://www.ncbi.nlm.nih.gov/pubmed/24019274</p>
<p>This retrospective analysis studied community pharmacies providing flu and group A streptococcus (GAS) testing. Participating pharmacies reported 661 visits for adult (age 18 and over) patients tested for influenza and for GAS pharyngitis. For the GAS patients, 91 (16.9%) tested positive. For the Influenza patients, 22.9% tested positive and 64 (77.1%) tested negative. Access to care was improved as patients presented to the visit outside normal clinic hours for 38% of the pharmacy visits, and 53.7% did not have a primary care provider.</p>	<p>Klepser D, et al. Utilization of influenza and streptococcal pharyngitis point-of-care testing in the community pharmacy practice setting. Research in Social Administrative Pharmacy. 2018. https://www.ncbi.nlm.nih.gov/pubmed/28479019</p>
<p>This survey analyzes Oregon pharmacy practices in the provision of hormonal contraception (HC) and evaluates if pharmacists' motivation to prescribe HC changed after 6 and 12 months of experience. The survey results demonstrated that pharmacist prescribing of HC continues to grow with almost 50% of pharmacists billing insurance for the visit. Visits take <30 minutes and the top 3 motivators continue to be enhanced access to care, reducing unintended pregnancy, and expanding pharmacists' scope of practice.</p>	<p>Rodriguez MI et al. Pharmacists' experience with prescribing hormonal contraception in Oregon. Journal of the American Pharmacists Association. December 2018. https://www.sciencedirect.com/science/article/pii/S154431911830339X</p>
<p>This umbrella review included 13 research syntheses, finding that the provision of preventive services at community pharmacies is shown to be effective at increasing immunization rates, supporting smoking cessation, managing hormonal contraceptive therapies, and identifying patients at high risk for certain diseases. Community pharmacies offer an ideal venue for the provision of preventive services due to their convenient location and extended hours of operation.</p>	<p>San-Juan-Rodriguez A, Newman TV, Hernandez I, et al. Impact of community pharmacist-provided preventive services on clinical, utilization, and economic outcomes: An umbrella review. Preventive Medicine. 2018. https://www.ncbi.nlm.nih.gov/pubmed/30145351</p>
<p>Among black male barbershop patrons with uncontrolled hypertension, health promotion by barbers resulted in larger blood-pressure reduction when coupled with medication management in barbershops by specialty-trained pharmacists. The mean reductions in systolic and diastolic blood pressure were 21.6 and 14.9 mmHg greater, respectively, in participants assigned to the pharmacist-led intervention than in those assigned to the active control. In the intervention group, the retention rate was 95%, with few adverse events, and self-rated health and patient engagement increased.</p>	<p>Victor RG, et al. A Cluster-Randomized Trial of Blood-Pressure Reduction in Black Barbershops. The New England Journal of Medicine. April 2018. https://www.nejm.org/doi/full/10.1056/NEJMoa1717250</p>

<p>This study describes the result of a pharmacist-driven, type 2 diabetes targeted, collaborative practice within an urban, underserved federally qualified health center. Pharmacists within a primary care team managed patients with chronic illnesses utilizing a collaborative practice agreement. Pharmacists had a significant impact on improving the health outcomes of patients with Type 2 diabetes, with significant improvements in patient attainment of A1c <9%, ACE inhibitor/angiotensin receptor blocker and statin use, and tobacco cessation at follow-up</p>	<p>Lokken J, et al. The impact of a pharmacist-driven, collaborative practice on diabetes management in an Urban underserved population: a mixed method assessment. Journal of Interprofessional Care. August 2019. https://www.tandfonline.com/doi/abs/10.1080/13561820.2019.1633289?journalCode=ijic20&</p>
<p>This article highlights three health systems – Yale-New Haven Health, Ascension, and the University of Illinois Hospital and Health Sciences System – that are utilizing pharmacists to provide healthcare services to underserved patients.</p>	<p>https://www.ashpintersections.org/2018/06/underserved-patients-rely-on-pharmacists-to-fill-care-gap/</p>