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Rx for Homeless Patients Present Financial, Medical Challenges

Health Care for the Homeless providers "jump through hoops" to meet their patients' needs for prescription drugs. They dispense drugs on site, according to the laws of their State; contract with local pharmacies; and take advantage of drug companies' patient assistance programs. Many participate in the U.S. Public Health Service 340B Drug Pricing Program. Still, they rarely have enough money to meet their patients' needs. This issue of Healing Hands examines some of the ways in which HCH projects address the complex and critical issue of access to pharmaceuticals, and specifies prescribing practices that providers recommend for the most effective care of homeless patients.

Retail prescription drug prices in the United States have increased an average of 7.3 percent a year since 1991, more than twice the average rate of inflation (2.5 percent).[1] Between 2001 and 2002, the average increase in drug prices was 9.5 percent, ranging from 5.3 percent in Maine to 12.6 percent in Tennessee.[2]

These trends are especially ominous for Health Care for the Homeless providers and their clients, 73 percent of whom had no health insurance coverage in 2002, compared to 15 percent of the general U.S. population.[3] People with very low incomes and those in fair or poor health are most likely to remain uninsured the longest. Many homeless people satisfy both of these criteria; out-of-pocket costs for prescribed medications are far beyond their means.

Many homeless patients present with both acute and chronic health care problems, such as trauma, upper respiratory infections, diabetes, hypertension, and heart disease. Some require multiple medications over long periods of time. In an era of decreasing resources and increasing needs, HCH providers must decide how to purchase and dispense medications, how to help patients in unstable living situations comply with treatment regimens, and how to treat pain in those with chemical dependencies or strong financial incentives to misuse medications. This article highlights a variety of approaches that HCH projects are using to meet these medical and financial challenges—in Arizona, California, Florida, Idaho, Louisiana, Montana, New York, Pennsylvania, Texas, and Wyoming.

ONSITE DISPENSING The ability to dispense prescription medications when and where the patient is seen is a top priority for HCH projects. The **Maricopa County Health Care for the Homeless Program in Phoenix, Arizona,** used to fax prescriptions for their patients' medications to the local public health department pharmacy, and the drugs would be delivered later that day. "But people didn't come back," says **Adele O'Sullivan, MD,** Medical Director. "We thought of it as a barrier that we couldn't get medications in their hand at the initial encounter."

Today, Dr. O'Sullivan says, her program stocks 35 to 40 common drugs in unit doses that cover about 90 percent of what they use in an average day. "People leave with their medications in hand." A former pharmacist, Dr. O'Sullivan now has a license to dispense medication from the Arizona State Board of Medical Examiners.

In similar fashion, the **Cheyenne Crossroads Clinic HCH program in Cheyenne, Wyoming,** recently began buying prepackaged and prelabeled prescriptions that Clinical Director **Connie Miller, FNP, MSN,** dispenses. "Before this, if we didn't have samples, we would give our patients a prescription, a voucher for the amount of the medication, and bus tokens to fill their prescription at a local pharmacy."

At the **Community Health Center of Lubbock, Texas,** HCH patients can fill their prescriptions at the United Coalition Pharmacy located in the health center building. Each patient gets a voucher that allows him

or her to purchase $100 a year in medications, which covers quite a few drugs, says **Debra Flores,** Homeless Health Care Coordinator. The pharmacy keeps a running tab and deducts what patients spend from their vouchers; the health center pays a dispensing fee.

Pharmacists dispense medications to homeless and low-income patients at the **Venice Family Clinic in Venice, California,** through clinic dispensaries. "We use our skills as pharmacists in patient counseling to improve compliance both with medications and with non-drug treatments," says **Ruth Smarinsky, PharmD,** Director of Pharmacy Services. "Our pharmacists suggest alternative drug therapies available through patient assistance programs, and the budget savings allows the clinic to see more patients."

The **New Orleans Health Care for the Homeless Program** has been approved by the State of Louisiana to operate a pharmacy but is waiting for the City of New Orleans to make improvements in the room where pharmaceuticals will be stored and dispensed, says **Florence E. Jones, MD,** Medical Director. The program recently lost its pharmacist, but is negotiating with Xavier University of Louisiana to have its pharmacy school send students to help out. In the meantime, Dr. Jones and a nurse practitioner can dispense medications to patients.

OFFSITE PHARMACIES Timely access to pharmaceuticals was the reason the **Boise Clinic** chose to contract with two local Rite-Aid pharmacies, according to **Kevin McTeague, MS,** Operations Officer for Terry Reilly Health Services in Boise, Idaho. Terry Reilly provides HCH services at two of its five medical clinics — the HCH clinic in Boise and a community and migrant health center in Nampa, 20 miles west of Boise. The Boise Clinic has no pharmacy of its own and had to fax prescriptions to the Nampa clinic, which sent medications back to Boise the next day. By contracting with two commercial pharmacies in Boise, one close to the HCH clinic and one downtown near the shelters, homeless patients in Boise now have same-day access to medications. "We need to make a connection with our patients and meet their needs when we see them," McTeague says. Patients get a laminated program card that identifies them as eligible for free medication.

The HCH program of **Yellowstone City-County Health Department in Billings, Montana,** provides services at four sites within eight blocks of the Community Health Center, where homeless patients can fill their prescriptions at the onsite pharmacy. Prescriptions are stamped "PHS-HCH" so the pharmacy knows it can fill the medication from the in-house 340B stock at no cost to the patient, says **Lori Hartford, RN,** Program Manager. Likewise, patients of the outreach-based **Unity Health System Health Care for the Homeless Program in Rochester, New York,** get prescriptions to fill at an outpatient pharmacy located in the health care facility that is home to the HCH program. Patients seen at off-site clinics may be given bus tokens to get to the pharmacy or case managers may transport them, says Program Manager **Sandra Stephens.**

PRESCRIPTION DRUG COSTS For many HCH projects, the cost of providing prescription and over-the-counter drugs to patients is the second largest expense after salaries. This is true in Billings, Montana, where the HCH program spends $90,000 of a $665,590 budget on drugs. It's also true in Cheyenne, Wyoming, where $18,000 is budgeted for medications out of a total clinic budget of $250,000. **Healthcare Center for the Homeless in Orlando, Florida,** receives $250,000 from the county for medications and adds $50,000 from its HCH grant, but last year it overspent its drug budget by $50,000. From October 2003 to February 2004, the center spent $213,000 on medications, according to CEO **Bakari Burns, MPH.**

Most homeless patients seen at HCH projects are uninsured, so the projects bear the full cost of their drugs. However, even patients receiving Medicaid may have trouble obtaining prescription drugs if they cannot cover the co-pay that many Medicaid programs charge; often, HCH projects find a way to cover these costs, as well. In Maricopa County, Medicaid patients must pay a $4 per month co-pay for generic medications and $10 for brand name drugs. "We do the math," Dr. O'Sullivan says. "If paying the co-pay is cheaper than paying for the medication, we find a way to cover the co-pay. However, the co-pay frequently is more expensive than using generic medications."

FORMULARIES Restricting formularies to commonly used generic drugs is one of the chief ways HCH providers try to control escalating prescription drug costs. In Maricopa County, Dr. O'Sullivan says, "We stock one thing in each class; for example, four antibiotics—one in each chemical group—and one anti-hypertensive in each pharmacological group. We don't stock "designer drugs"—second, third, and fourth generation medications like broad-spectrum antibiotics or proton pump inhibitors." Cost isn't the only reason for using generic medications, however. "Many people respond well to generics," Connie Miller says. "The worst thing you can do is start your patients on a medication they can't afford which you can't continue to provide."

Keeping tight reins on a restricted formulary can be difficult, says **Mary McManus, RPh, PhD,** Associate Professor at the Nesbitt School of Pharmacy at Wilkes University in Wilkes-Barre, Pennsylvania. "All it takes is one drug to bust the budget."

In a unique collaboration with the local Commission on Economic Opportunity, the Nesbitt School's Pharmaceutical Access Project provides free prescription medications to six free clinics, including the **McKinney Clinic's HCH project in Wilkes-Barre, Pennsylvania.** Initially funded by a grant from the Robert Wood Johnson Foundation, the Pharmaceutical Access Project purchases prescription drugs with donations from the United Way and other philanthropic organizations. With $25,000 in annual donations, the project can support approximately 10,000 prescriptions a year, largely by providing them from a formulary that relies completely on generic drugs. Fifty percent of its drug resources go to support the HCH site, McManus says. (For more information about the Pharmaceutical Access Project, send inquiries to Mary McManus at *mcmanus@wilkes.edu*.)

340B PROGRAM Section 340B of the Public Health Service (PHS) Act, enacted into law as part of the Veterans Health Care Act of 1992, authorizes significant cost savings on covered outpatient drugs to a group of organizations identified in the Act that include community and migrant health centers, HCH projects, and Federally Qualified Health Center look-alikes, among other programs. "The discount is equal to and in some cases better than the Medicaid rebate amount," says **Freda Mitchem,** Director of Systems Development for the National Association of Community Health Centers (NACHC). The discount amounts to about 15 percent off average manufacturers' prices, Mitchem says.

There are a number of ways agencies can choose to participate in the 340B program (see box). Whichever method they choose, Mitchem says, "There is no excuse for any HCH project that buys or subsidizes drugs not to buy at 340B pricing." A NACHC survey indicated that health centers participating in the program saved an average of 25 to 50 percent for covered outpatient drugs over what they had been paying.[4]

"The 340B Drug Pricing Program has been a huge benefit because we get drugs at a highly reduced price," says Bakari Burns. Because 340B prices may change quarterly based on drug company contracts, HCH providers try to economize where they can, notes Ruth Smarinsky of Venice Family Clinic. "When there is a good price on a particular drug we use frequently, we'll order a lot that quarter."

PATIENT ASSISTANCE PROGRAMS Making liberal use of drug companies' patient assistance programs, which provide free medications to uninsured individuals at or below poverty level, is another way many HCH programs cut their drug costs. In fact, what a health care program receives in free medications may dwarf its pharmacy budget. Last year, the Venice Family Clinic received between $4 million and $5 million from patient assistance programs, compared to its pharmacy budget of $130,000. On a smaller scale, the Cheyenne Crossroads Clinic matched its

340B IN A NUTSHELL

The following information is provided by Freda Mitchem, Director of Systems Development at the National Association for Community Health Centers (NACHC). See NACHC's technical assistance publication for more information[3] or visit the Bureau of Primary Health Care's Office of Pharmacy Affairs (OPA) online at http://bphc.hrsa.gov/opa/.

Health Care for the Homeless Projects (HCHPs) have to decide how they plan to handle a pharmacy benefit for their patients. This requires both a business and mission analysis of what is needed to ensure access to prescription drugs for their patients, how to get the drugs to their patients, what it will cost, and what the HCHP can afford. There are several main models, including the use of drug company patient assistance programs (see lead story). The U.S. Public Health Service 340B Drug Pricing Program is commonly used in one of three ways (sometimes several of these models are used at the same time):

1. **Provider Dispensing** – The HCHP can buy drugs from a wholesaler at 340B prices and have their providers dispense them to health center patients if State law permits. Using this model, the HCHP will have to determine how to store and secure the drugs consistent with State and Federal requirements. Formularies under this scenario typically are limited to the most commonly used medications for frequently seen conditions.
2. **Licensed, In-House Pharmacy** – An HCHP or Federally Qualified Health Center (FQHC) can establish and operate its own licensed pharmacy just for its patients. This usually requires having a high enough volume of prescriptions to justify the cost of running a pharmacy as well as the ability to recruit and pay a pharmacist. There are approximately 350 migrant, homeless, and community health centers (some jointly funded programs) that have licensed in-house pharmacies. The center buys drugs at 340B prices and dispenses them to any health center patient—privately insured, with Medicaid or Medicare, or uninsured. The center decides what the charges will be for drugs, what the discounts will be for uninsured patients with incomes below 200 percent of poverty, and what the dispensing fees and co-payments will be. The center's pharmacist dispenses the drugs.
3. **Contracted Pharmacy Arrangements with Retailers** – An HCHP can have a contracted pharmacy arrangement where it contracts with a retailer to dispense drugs to its patients. The health center buys at 340B prices and the contract pharmacy dispenses the drugs. The HCHP sets the prices, discounts, and co-payments that it requires for the drugs. The HCHP generally has the wholesaler ship the drugs to the contracted pharmacy and bill the HCHP for them (a "ship to" "bill to" arrangement permitted under the 340B guidelines). Under the replenishment model, the pharmacy can upfront the stock and the HCHP replenishes it from stock bought from its wholesaler at 340B prices.

   Under this model, the HCHP must negotiate a written agreement with a retailer that covers the pharmacy's dispensing fee and any additional administrative costs required to keep track of the center's drugs, prepare orders, and reconcile money. This agreement has to include a mechanism to identify eligible center patients. The HCHP also needs to have some form of audit mechanism in place to make sure that its drugs are only being dispensed to its patients.

As required by statute, the Health Resources and Services Administration (HRSA) has established a prime vendor program for use of 340B participating covered entities. The prime vendor distributes drugs and negotiates prices with manufacturers to try to obtain price reductions even greater than the formula required by law. HRSA encourages covered entities to use the prime vendor program unless they can document that they get better prices and services under another arrangement. Information is available on the OPA Web site. For more information on how to structure a pharmacy benefit, contact the HRSA Pharmacy Support Center (see the OPA Web site or call 1-800-628-6297).

entire clinic budget of $250,000 with in-kind medications—patient assistance programs and drug samples—amounting to nearly 14 times its $18,000 pharmacy budget.

"Patient assistance programs can be difficult to negotiate, but if these are the hoops we have to jump through to get free medication for our patients, then we learn to jump through hoops," says Lori Hartford. The paperwork is time consuming; there is no standardization in rules, forms, or eligibility requirements among the various drug company programs; and many of the companies are behind in filling orders, delaying receipt of needed medications that HCH projects have to purchase from other sources in the meantime. On the positive side, patient assistance programs allow HCH providers to prescribe newer medications, including some that feature once-a-day dosing, which helps improve treatment adherence, Dr. O'Sullivan says.

Staff support is essential to make patient assistance programs work for homeless patients. At the Community Health Center in Billings, three full-time staff (pharmacy technicians and clerical support staff) are dedicated to the Medication Assistance Program that helps patients complete application forms. Staff salaries are paid by the United Way and the Federal Community Development Block Grant (CDBG). Soon, the HCH project will begin using its own clerical staff to fill out patient assistance forms, as well.

"If someone is on seven different medications for chronic conditions like heart disease, high blood pressure, and diabetes, we can't continue to pay forever," Hartford says. "We act as a bridge until the patient assistance medications come in." Medication Assistance Program staff generate patient assistance program application forms from *www.meddataservices.com;* other HCH projects use the Volunteers in America Web site at *www.rxassist.org*.

The Community Health Center of Lubbock also has staff dedicated to filling out patient assistance forms—one staff position is funded by the health center, and the other by a local provider, Covenant Outreach Services. Before they used patient assistance programs, there were no other alternatives after homeless clients' $100 vouchers ran out, Flores recalls. What's more, their diabetic patients have greater blood sugar control (lower hemoglobin A1c levels), now that they can receive regular medications through the patient assistance programs.
In other programs, nurses, case managers, pharmacy technicians, and clerical staff help patients fill out the required forms. It can take up to 6 weeks to receive a medication order; most drug companies send a 90-day supply, which HCH projects either dole out one month at a time or dispense all at once. Connie Miller, whose program in Cheyenne, Wyoming, hands out a 90-day supply of most medications, for lack of storage room, indicates that certain drugs (such as the anxiolytic Klonopin®) are only dispensed one month at a time.

FREE SAMPLES HCH programs also make use of drug companies' free samples as a way to cut costs for their patients, but like the patient assistance programs, the use of samples can be problematic, as well. The FDA strictly regulates the use of samples, which must be logged in by lot number and expiration date. At the Venice Family Clinic, "some doctors have brought in garbage bags full of samples, and we had to itemize and account for every tablet," Smarinsky says. "That's a lot of paperwork for drugs we might not even use, so we only use samples received from drug manufacturers directly."

Expiration dates are a problem with sample medications. "We actively solicit drug samples from drug companies and doctors in the area because we like to get them before they expire," Bakari Burns says. "We can't afford the liability of using expired medications, even though we know the drug is probably still good." (For guidance in determining whether expired medications are clinically safe and effective to use, see "Using Expired Medications: A Murky Issue" in the November 1998 issue of *Healing Hands,* available at *www.nhchc.org*.)

OTHER RESOURCES When the 340B program, patient assistance programs, and samples are not enough to meet their patients' need for medications, HCH staff reach out to the community. "Collaboration is a critical part of making things happen," Hartford says. The HCH project in Billings has done fundraising to supplement its pharmacy budget. They also help their patients enroll in a State plan that provides up to $450 a month for medications to people with severe and disabling mental illnesses who are not eligible for, or are not yet receiving, Medicaid.

Lutheran Social Services, Catholic Family Services, and local churches in Lubbock, Texas, sometimes help with prescription drug costs for homeless patients. The local community mental health center in Cheyenne, Wyoming, provides sample medications for homeless patients while patient assistance program applications are being processed.

PAIN MEDICATION One difficult issue with which all HCH programs grapple is how to treat pain in a population with high rates of addiction. Some programs, such as those in New Orleans and Rochester, New York, have a blanket policy of not providing any narcotic pain relief through their programs. In Boise, providers will write prescriptions for a short course of narcotics. "We have a hard and fast rule that we're not a pain management clinic, but we don't want to deny people who are in severe and acute pain," says Clinic Manager **Barbara Youren, FNP, RN.** "We do see drug-seeking patients, but any family practice does," she adds.

Although HCH providers should be alert to the possible misuse of pain medications, not every homeless person who asks for pain relief has an illicit motive. "Just because someone is homeless doesn't mean he or she is not in real pain," warns Lori Hartford. The formulary in Billings includes what Hartford calls "baby pain medications" like Tylenol 3® and Fiorcet®. To help patients who need pain relief, providers in Cheyenne sometimes combine two of the lesser pain medications, such as ibuprofen and acetaminophen, according to Miller. Research supports this mode of treatment. In a University of California, Irvine, College of Medicine study, patients recovering

from knee or hip replacement surgery felt less pain, recuperated faster, and needed fewer narcotics when given a combination of common pain relief medications.[5]

ADHERENCE Failing to take medications as prescribed is not a problem unique to homeless people. Estimates are that 50–75 percent of Americans do not take prescribed medications properly; the rate of noncompliance is especially high for people with chronic illnesses.[6] For homeless people, problems adhering to treatment are compounded by the lack of a safe place to store medications, lack of access to refrigeration, irregular mealtimes, and cognitive problems secondary to mental illnesses, substance use disorders, or normal aging.

In Billings and Maricopa County, HCH providers fill medicine boxes for patients whom they expect to have a hard time taking prescribed medications, especially those who must take more than one dose or multiple medications each day. Providers in Billings buy pill boxes at the local Dollar Store. In Maricopa County, providers also use positive incentives. As part of the Cardiovascular Health Disparities Collaborative, Dr. O'Sullivan and her colleagues give patients a $5 coupon for a sandwich at Subway if they come back before their medication has run out. "We don't have confirming data yet, but anecdotally, it's working," Dr. O'Sullivan says.

Some of the strategies HCH providers use to help patients adhere to medical treatment regimens are summarized in the next article. They include once-a-day dosing, dispensing small amounts of medications at a time to ensure follow-up, and educating patients about safe storage of their medicine.

HCH Clinicians Adapt Prescribing Practices to Optimize Care for Homeless Patients

The following material is excerpted from a prepublication draft of Adapting Your Practice: General Recommendations for the Care of Homeless Patients, *prepared by the Health Care for the Homeless Clinicians' Network. Publication is expected by June 2004.*[7] *Look for these and other recommended clinical practice adaptations for the most effective care of homeless patients on the National Health Care for the Homeless Council Web site at* www.nhchc.org.

SIMPLE REGIMENS Use the simplest medical regimens warranted by standard clinical guidelines to facilitate treatment adherence. Consider medication expense and duration of treatment in selecting medications for homeless patients. Pill count, frequency, and dosing are extremely important for homeless patients. If clinically indicated, once-a-day, directly observed therapy is preferable, especially for those who may be unable to adhere to a more complex regimen.

DISPENSING Dispense small amounts of medications at a time, if transportation to and from the clinic is available and affordable for the patient, to allow for closer follow-up and limit opportunities for misuse that may occur with multiple authorized refills. Dispensing medications on site is more effective than sending homeless patients to an offsite pharmacy with a prescription.

MISUSE Recognize the potential for medications and delivery devices to be lost, stolen, or misused. Inhalants, bronchodilators and spacers, pain medications, some anti-hypertensives, and syringe needles are frequently misused by people with chemical dependencies. Albuterol is used to enhance the effects of crack cocaine. Clonidine extends the effects of heroin and reduces withdrawal symptoms for people addicted to opioids. Insulin syringes may be misused to inject illicit drugs. These factors may provide an incentive for some individuals to report having a condition not actually diagnosed.

STORAGE/ACCESS Educate the patient about safe storage of prescribed medications. Ask if the shelter can store medications and make them easily available when needed; explain that medications are costly and necessary for the patient's health. Or allow homeless patients to store medications at the clinic and come there daily for treatment. This protects against loss, theft, or confiscation if the patient is arrested for public nuisance offenses, and assures that medications are taken as prescribed. If the patient does not have access to refrigeration, avoid prescribing medications that require it.

SIDE EFFECTS Medications that make people feel sicker or more fatigued and interfere with survival on the streets should be avoided. Side effects are a primary reason for nonadherence to treatment. Prescribe medications with fewer/less severe GI and other side effects. Avoid prescribing diuretics if the patient does not have easy access to a restroom or hydration, or will not be able to return for laboratory tests necessary for monitoring them. If medications can be taken with food, provide nutritious snacks to prevent nausea which often results from taking medications on an empty stomach. Be more aggressive with homeless patients in treating side effects or changing medication, if an equally effective alternative is available. If alternative medications with fewer negative side effects are not medically indicated, treat side effects symptomatically.

AIDS TO ADHERENCE To facilitate treatment adherence, use a harm reduction approach, outreach, intensive case management, directly observed therapy, and medication monitoring. Aggressive outreach and case management will contribute to successful out-

comes for active substance users. Address obstacles to taking medications appropriately. Ask the patient, "Who can help you take your medicine and keep track of it?" If clinical symptoms or test results indicate nonadherence, find out why the patient is not taking medication(s) as prescribed and address the reasons. Consider use of pill boxes to help patients with memory loss keep track of medications, which also makes resale more difficult.

ANTIBIOTICS Emphasize that all antibiotics prescribed must be completed. ("Don't stop when symptoms cease or use for the next infection.") Explain the risk of developing drug resistance if medications are not taken consistently or appropriately. Urge patients to use standard measurements for liquid preparations, (not just "a swig"). Provide a measuring device.

ANALGESIA Recognize that a number of morbidities commonly seen in homeless patients—including untreated dental problems, ear infections, hepatitis, and traumatic injuries—can result in chronic pain. Work with the patient/family to understand the underlying cause of pain, prescribe appropriate pain medication, and document why you prescribed it. Remember that some drugs, including methadone and other narcotics, can decrease or increase the efficacy of pain medications. To avoid overmedicating or contributing to drug-seeking behavior, encourage the patient's cooperation with a contract specifying the plan of care and designating a single provider for pain prescription refills.

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