

Reaching the Underserved

CONNECTING MOBILE & HOMELESS PEOPLE TO THE HEALTH DISPARITIES COLLABORATIVES

March 2006

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WELCOME

Health Care for the Homeless (HCH) Clinicians' Network and **Migrant Clinicians Network (MCN)** are pleased to welcome you to the fourth edition of our joint e-newsletter, *Reaching the Underserved: Connecting Mobile & Homeless People to the Health Disparities Collaborative*. HCH Clinicians' Network and MCN serve as National Partners to the HRSA Health Disparities Collaboratives. This newsletter focuses on medications—uses, resources, and cultural factors. Medications are a challenge for all CHC patients, but perhaps homeless, mobile, and migrant patients have some of the biggest challenges to comprehensive quality medication management. Safety and accessibility are especially concerning for these populations. Literacy, accessibility, cost, perceived need and benefit, and culture all play a role in medication use and adherence. As you encounter medication issues, please let us hear from you in regard to these issues!

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TOOLS AND RESOURCES

:: Meds Here and There: A Comparison of Diabetes Meds Across Borders

How does your clinic’s medication profile for diabetes compare to a medication profile from Mexico? Many of our Hispanic migrant (and perhaps homeless) patients travel back and forth across US and Mexican lines. Even if they don’t travel, many Hispanics have access to medications sent from Mexico. Clinicians often express frustration that their patients frequently change medication regimens. Cost and access may play a large part in this dilemma. Joshua Messer, MD studied the availability and cost of commonly prescribed diabetes medication in US community health centers and in Mexico. He found significant differences between the two countries. For instance, Glyburide 5mg tabs are easily available in Mexico, while Glyburide micronized is very difficult to obtain. Glypizide ER and Metformin ER are also hard to get, while Metformin 500mg is more readily available. Across the board, meds were significantly less expensive in Mexico compared to US retail prices, some by 600%. Based on these findings, the following recommendations for decision support are made:

- CHCs should use the list of most commonly obtained diabetes meds as a reference guide for treating patients with access to Mexican products.
- The newer extended release meds should be avoided for patients who may travel between the US and Mexico, or obtain meds from Mexico.
- Clinicians should recognize that access to lower cost medications in Mexico may be a strong factor in patient adherence.

For the full report on this topic, including excellent quick reference guides in table format, see MCN’s *Streamline* article: “Diabetes Medication Costs”, Vol. 11, Issue 6;

http://www.migrantclinician.org/news/streamline/20051112_mcn_streamline.pdf

Let us hear how patients with other chronic conditions, such as hypertension, depression, and chronic pain, experience medication differences across borders.

:: A Complete Medication History: Capturing the Use of Alternative Meds

Many clinicians were not trained to take a medical history that includes the use of complementary and alternative medications (CAM). Dr. Kathi Kemper, of Wake Forest University Medical Center, has developed a tool for history taking that incorporates CAM use with over-the-counter and prescription drug use history. She divides the medication history into the following four sections:

1. Biochemical—this includes prescription, over the counter meds, herbs, teas, vitamins, and supplements.
2. Lifestyle—This includes diets, exercise, and mind-body therapies such as yoga
3. Biomechanical—Massage, chiropractic, surgery
4. Bioenergetic—Acupressure/puncture, hypnosis, prayer, healing touch, religious or cultural healing rituals, and homeopathy fall into this category.

Dividing your intake into these four categories allows the patient to respond more fully to your history questions. For some patients, a bioenergetic model may be more culturally appropriate than a biochemical one, but they may not consider reporting it to you unless you ask. Most of us use several types of remedies for our ailments, from chicken soup to Sudafed. Try a PDSA using these categories and tell us what you learned!

For more on CAM, go to www.altmedicine.org and www.cccam.nih.gov

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SUCCESS STORIES

:: Depo Parties: An Insight by Dr. Ed. Zuroweste

It has been known for many years that migrant farm workers rely on each other for treatment of common illnesses and have access in their home countries to medications that are only available by prescription in the US. Injections of various types have been a mainstay of this “self-treatment”. The most common type of medications injected have been antibiotics and vitamins. There has always been a concern among migrant health providers that this practice poses risks of injection site infections, hepatitis and HIV.

This past year I learned from a migrant health provider in Oklahoma of the recent practice of Mexican migrant women attending “Depo parties”, not unlike “Tupperware parties”. At these gatherings a group of women come together socially and during the evening someone (often the recognized health expert in the group) offers Depo-Provera injections for women who want or need contraceptive services. According to this source, these parties were occurring about once a month and this health care provider was quite concerned that these women were getting their injections more frequently than the indicated every three month cycle. There was also concern about dosage, discussion of side effects, identification of contraindications etc.

I have recently heard exactly the same story in Pennsylvania from two individuals who are immigrants from Mexico. They both told me that they are receiving the Depo-Provera injections every three months. Their overall understanding of the effects, side-effects and contraindications to the medication was minimal.

Migrant clinicians need to be aware of this practice and specifically ask their female migrant patients if they or anyone they know is participating in “Depo parties”. The obvious clinical concerns related to this practice include but are not limited to: injection site infections, exposure to hepatitis B, C and HIV, inappropriate dosage or frequency of injection, inadequate education of effects and side effects and inappropriate selection of individuals to receive the medication. MCN would be very interested in hearing from front line providers regarding the current self-administration of Depo-Provera and other injectables in the migrant farm worker population. Please contact Ed Zuroweste MD, Medical Director, MCN at kugelzur@migrantclinician.org.

:: 340B Simplified

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 minimum 340B discount is equal to the Medicaid rebate percentage (15.1%). For the most part discounts are higher than this and most are 20-50% off the average wholesale price

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 or visit HRSA’s Office of Pharmacy Affairs (OPA) online at <http://www.hrsa.gov/opa/>.

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 or Federally Qualified Health Center (FQHC) 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 program 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 or Federally Qualified Health Center (FQHC) 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 health center sets the prices, discounts, and co-payments that it requires for the drugs. The health center generally has the wholesaler ship the drugs to the contracted pharmacy and bill the center 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 health center 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 health center 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 requires covered entities to use the 340B program and 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 Services Support Center (see the OPA Web site or call 1-800-628-6297).

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SIMPLE SOLUTIONS

Decision Support: How do your Patients Obtain Meds?

Most CHC clinicians struggle to find low-cost medications for their patients and to provide patients with a reliable medication plan. For mobile patients and uninsured patients, such as most migrant and homeless patients, access to medications is a major issue. Are you aware of where your patients actually get their prescriptions filled? Do you know how they obtain them or who they go to for medication advice? Who is their source for alternative treatments? A simple survey may help your clinicians become better able to anticipate patients’ medication needs. Some questions you may want to ask: (Many of these can have answers to choose from instead of being open-ended)

- Where do you get your prescription medications? (tiendas, order by mail, clinic, American drugstore, friends, bring from Mexico)
- How many different pharmacies/drug stores do you use?
- What do you do if your medicine runs out?
- How much does your medicine cost you each month?
- Where do you keep/store your medicine?
- Who gives you advice about your medicine? (may put in categories such as friends, family, pharmacist, doctor, nurse, promotor/a, curandero/a)
- Where do you get your other medicines, the ones without a prescription? Such as teas, creams, vitamins, herbs, aspirin? (get from shelters, clinics, tiendas, curandero/as, family/friends, other)
- How do you know if a medicine or treatment is safe for you to use?
- Do you receive injections for any of your health needs?

Many providers are unaware of not just which retail pharmacy their patients use, but of all the alternative “providers” and “clinics” available to their patients. Dr. Kristine McVea (medical director of One World CHC) studied the use of lay injectors in the NC migrant population. She found that approximately 20% of patients went to a local lay healer for injections as an adjunct to CHC visits. Lay injectors may be common in many groups of recent immigrants, as they are common in countries of origin. Many cultures believe that injections are superior to oral meds, and use injections for infections, vitamins, and even infant teething. Asking your patients about injection use—in a non-judgmental manner—may yield significant findings on the cultural practices in your area. Be aware that patients will not want to convey any information that may result in adverse actions to themselves or their community members.

Decision Support and Self-Management: Label Language

CHC’s are typically careful to provide information in a patient’s primary language and at the appropriate literacy level. But do your Spanish-speaking patients get their medication information delivered with such care? A recent article in the Journal of Health Care for the Poor and Underserved, found that Spanish prescription labels were not always available to Spanish speaking patients. Interestingly, the small pharmacies did a better job with Spanish labeling than did the larger chain pharmacies. All pharmacies required a patient to first ask for Spanish before giving it. Some relied on a computerized Spanish translation, and some of these did not have anyone at the pharmacy who could reliably check for accuracy with the computer-generated translation. What’s the big deal? Patients have ingested toxic treatments, such as lice shampoo, when not understanding “topical” v. “oral”. Small misunderstandings can be deadly! What is your center doing to recognize this issue?

See the abstract for the journal article at the following link: (be sure to paste in both lines)

http://muse.jhu.edu/journals/journal_of_health_care_for_the_poor_and_underserved/toc/hpu17.1.html

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FEEDBACK FROM THE FIELD

Tiendas are in the News!

Tiendas, those little Mexican or Hispanic stores that now appear in even small rural towns, provide more than a taste of home to their customers. In addition to importing foods, wiring money, and providing a central location for folks to visit, tiendas also may be offering unregulated medical care. It’s not only tiendas, but also other marketplaces with similar missions, selling goods to immigrant groups, that serve as medical centers for their clients. A number of news articles have recently addressed this issue. Misunderstandings go two ways: both US medical personnel and immigrant patients need assistance in distinguishing safe lawful practices from harmful ones. Here we’ll highlight two recent stories:

- The NC Medical Board published a story in 2005 called “Tiendas and Contraband Pharmaceuticals.” While it quite accurately pointed out that there is a two tier system for obtaining prescription medications in this country, it failed to recognize the access issues and cultural factors that play a vital role in patient medication management. Not only do some patients self-diagnose and self-treat, but for some immigrants, this represents the only option of which they are aware. For others, this option is considered good because it is trustworthy, obtained from people who know them and can speak to them. The NC Board suggested reporting patients who use this illegal method of obtaining prescriptions via tiendas. But our concern as editors is that clinicians must

educate and integrate before all else—the patients are not choosing to “break the law” in many cases, but are doing their best in a foreign situation. CHCs can play a vital role in linking tiendas, pharmacies, patients, and providers so that all are aware of US prescription drug practices and so that those in need can have safe, effective, affordable medicines. To read the NC Medical Board story, please follow this link:

<http://www.ncmedboard.org/Clients/NCBOM/Public/PublicMedia/no205.pdf>

- The Associated Press recently reported that “Unsafe Imports Find Way to Store Shelves” (David B. Caruso, NY, 3/20/06). It reports that unregulated foreign medicinal imports are flooding shops frequented by immigrants and those seeking alternative remedies. Of 13.7 million products, only about 75,000 are sampled for safety concerns. It cites the sale of a compound sold for flu-like illness that contained mercury levels 2,190 times higher than deemed safe. Similar articles have reported lead toxicity in children’s vitamins and candies, and heavy metals in creams, pills, and soaps from around the world. There is tremendous variation in the ingredients found in unregulated medications, whether labeled or not. A complete medication history includes a check on these over the counter products used as adjuncts to good health. What PDSA cycles might help you deal with this problem in your area? Please let us know what you find!

http://muse.jhu.edu/journals/journal_of_health_care_for_the_poor_and_underserved/toc/hpu17.1.html

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