The Pharmacy Safety Net in California

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Introduction

The Institute of Medicine of the National Academy of Sciences asserts that the greatest cost to society of the uninsured population is not the cost of providing health care, but rather the cost of poorer health and premature deaths for the uninsured [1]. As the population ages and the incidence and severity of chronic disease grow, access to care through pharmaceuticals increasingly will be a critical issue facing the nation. Lack of regular access to needed medications is a primary example of the delayed and inadequate care that leads to poor health for the uninsured and other underserved populations. As the number of uninsured rises, the use and cost of drugs increase, and financial pressures on the safety net build, the pharmacy safety net and its pharmacists will increasingly be stretched. Interventions are needed to build the capacity of the pharmacy safety net workforce in order for it to meet the needs of society's most vulnerable populations.

Overview

The term *safety net* commonly refers to health care providers that provide care regardless of a patient's insurance status, ability to pay, or immigration status. Defined primarily by its patient profiles, the safety net serves the uninsured, indigent, low-income underinsured, and those covered by Medicaid or other state and local government programs. The core of the safety net is public hospitals, community health centers (CHCs), and county and nonprofit clinics. In addition, private, nonprofit hospitals increasingly are becoming disproportionate share hospitals (DSHs) and, thus, part of the safety net [2]. Some safety net providers are mandated by law to provide services to the indigent (e.g., DSHs), while others provide care to this population as part of their organizational missions. Although specialty services, such as mental health and surgical care, are provided to varying degrees within the safety net, the majority of the safety net focuses on primary care.

As many recent reports have concluded, the safety net is in crisis [3, 4]. The major factors contributing to the stress on the safety net are the growing numbers of uninsured and underinsured and the unstable and weakening funding mechanisms, creating a system that is impacted simultaneously by growing demands and reduced resources. Approximately 6 million Californians are uninsured and 8 million are underinsured [3]. In 2004, The California Endowment commissioned three studies on the impact of state and local budget cuts on the safety net. All three reports concluded that "the consistent eroding of funding for safety net services – through state funding cutbacks to counties and reductions for nonprofits – has jeopardized the capacity of counties and safety net providers to administer key health and human services" [3]. One of the studies found that nonprofits that provide health, human and social services within the safety net experienced a significant reduction in revenue in 2003: an average decrease of 22.5% for 40.7% of the safety net nonprofits [5].

Pharmacy services in the safety net are provided through in-house pharmacies, in-

house dispensaries, and on-site and off-site contracted pharmacies. At in-house pharmacies pharmacists dispense medications, while at the dispensaries, nonpharmacist health care providers (e.g., physicians and nurses) dispense the medications while pharmacy consultants provide oversight of the dispensary.

Available state data provide a count of safety net providers that have on-site pharmacies or dispensaries (see Table 1); data to distinguish pharmacies from dispensaries in the safety net are not available. Data identifying the number of pharmacists who work in the safety net, either as on-site pharmacists or as consultants, however, are not available.

Pharmacists in the safety net fill two roles: staff pharmacist and pharmacy consultant. Staff pharmacists divide their time between a variety of responsibilities, including dispensing, patient education, disease management, and drug procurement. The time a safety net pharmacist spends on each of these tasks varies widely and depends on that pharmacist's particular environment.

The primary role of the pharmacy consultant is to ensure that a clinic is following regulations. In this role, the consultant is required to visit the clinic at least quarterly and complete two reports annually documenting the clinic's adherence to regulations on proper storage, proper personnel, and proper staff training. The clinic includes the consultant's reports as part of its inspection report or payer audit. The pharmacy consultant does not fill prescriptions.

In most cases, the consultant is not part of the pharmacy clinic staff. The rare dispensary that has an on-site pharmacist is the only exception. At these dispensaries, the staff pharmacist is usually, but not always, the consultant for the dispensary as well. The consultant, in his/her external role, may work full-time as a pharmacy consultant, sometimes to multiple dispensaries, or may work part-time as a pharmacy consultant while also working elsewhere as a staff pharmacist.

Table 1: California's Safety Net: Pharmacies & Dispensaries

	Hospitals		Clinics	
	Public	Nonprofit DSH	Free, Nonprofit & Community	County
Total Number	83 [(1)]	36 [(1)]	834 [(2)]	167 [(3)]
Number with Pharmacy or Dispensary	56 [(1)]	35 [(1)]	476 [(4)]	25 [(4)]
Number of Pharmacists	Unknown	Unknown	Unknown	Unknown
Number of Pharmacy Consultants	Unknown	Unknown	Unknown	Unknown

Sources:
[(1)] OSHPD Annual Hospital Disclosure Report Year 28
[(2)] OSHPD Primary Care Clinics Listing as of December 31, 2004
[(3)] California Association of Public Hospitals and Health Systems List as of May 25, 2005
[(4)] California Board of Pharmacy as of March 1, 2005

Financing

Safety net providers rely on the same patchwork of funding sources that pay for other health services for the uninsured. Medicaid and federal grants are the two largest contributors to the safety net. Medicaid is the major source of funding for both safety net hospitals and CHCs, accounting for approximately 38% of safety net hospitals' operating revenue and 35% of CHCs' operating revenue in 2001 [6]. The continuing debate over Medicaid drug benefits amplifies the financial pressures on safety net providers. Safety net hospitals also receive funding through federal grants (primarily from the Health Resources and Services Administration [HRSA] Bureau of Primary Care Section 330 of the Public Health Service Act), DSH funding, and state and local funds. Like safety net hospitals, some CHCs also receive federal grant funding; CHCs also receive private donations.

To fund and procure prescription medications, safety net providers turn to a variety of sources, including federal drug discount programs such as the 340B Drug Pricing Program (see sidebar), patient-assistance programs (PAPs) (see sidebar), samples from drug companies, and, to a much lesser extent, donations from area physician offices. By all accounts, procuring drugs for safety net patients is a tedious, complex, and continuous challenge for safety net pharmacists, requiring not only time and detail-oriented attention, but also creativity. Pharmacists must balance the competing and equally critical needs for quality patient care and cost containment.

Not surprisingly, providing prescription drugs to patients who are unable to pay for them significantly improves their health outcomes [7]. To achieve this, safety net pharmacists spend considerable time pasting together a collage of procurement and funding options. For example, acquiring a specific drug for a single patient could involve a combination of a drug sample (ideally used only until a more stable resource for the drug comes through) and a PAP (which in most cases requires individual patient-specific paperwork). In addition to combining procurement methods in a feasible manner, pharmacists also contend with continually changing programs and program requirements, requiring pharmacists to be flexible and to stay informed.

340B Drug Pricing Program

The federal 340B Drug Pricing Program requires drug manufacturers to provide outpatient drugs to certain covered entities (including HRSA grantees, FQHCs [Federally Qualified Health Centers], and FQHC look-alikes) at a reduced rate. The 340B price is the highest price a 340B eligible provider would have to pay for a given drug, meaning providers may also negotiate for lower prices. 340B prices are reported to equal approximately 50% of the average wholesale price (Schodelmeyer, Prime Institute, University of Minnesota, 2001) [8].

Patient-Assistance Programs (PAPs)

Through patient-assistance programs (PAPs), pharmaceutical companies offer free or low-cost medications for qualified adults who are unable to pay for the drugs they need. Nearly all large pharmaceutical companies and many smaller companies provide their brand-name drugs as part of their PAP. "An estimated 150-200 PAPs are now operating, offering some 850-1000 drugs to eligible patients" [9].

Strengths

The greatest strength of the pharmacy safety net is the pharmacists themselves, who contribute quality care and cost containment

skills along with a commitment to their patient population. With their extensive knowledge of drugs and the drug delivery system, pharmacists are uniquely qualified to identify those medications that will not only meet each individual patient's medical needs, but also will keep overall costs down. Drugs are increasingly more difficult to sort through; pharmacists' expertise in using evidence-based practice to evaluate therapeutic equivalence and select substitutions that achieve cost-effective care is particularly useful in CHCs, which typically do not have Pharmaceuticals and Therapeutics (P&T) committees to create drug formularies.

In a health care environment where pharmacists are in short supply, pharmacists may choose to work in the safety net both out of concern for the populations they serve and for the varied practice opportunities they will encounter. Within the safety net, pharmacists are able to work directly with their patients and to use their creativity to ensure their patients receive the medications they need. In addition to professional opportunities, working in the safety net may provide pharmacists with a better work-life balance as some safety net settings tend to have more limited hours and more part-time options than non-safety net pharmacies.

Challenges

In addition to traversing the rocky road of drug procurement, pharmacists in the safety net are faced with several other challenges. Issues that affect the entire field of pharmacy – increased use and cost of drugs and workforce issues – have a particular impact on safety net pharmacists, while patient acuity, cultural competence, and lack of leadership opportunities are challenges that are especially unique to the safety net.

Pharmacy services increasingly are used to manage chronic disease, and, in some cases, reduce the need for more invasive forms of treatment (e.g., fewer surgeries to treat ulcers). Meanwhile, drugs, particularly newer drugs, are increasingly expensive. This combination of increased use and cost of drugs makes pharmacy services a primary cost driver in the health care system, straining already large safety net pharmacy budgets, often the second largest line item behind staffing. As a result, safety net pharmacists are continually pressured to procure quality medications at cost-efficient prices, a challenge that requires expert knowledge, determination and creativity.

The recruitment and retention of pharmacists and other highly skilled medical professionals is one of the top challenges facing the safety net. As evidence of the challenge, one reason dispensaries within the safety net do not convert to pharmacies is that they cannot assure coverage of the pharmacists' vacation and sick time. Lack of knowledge among pharmacists and pharmacy students about the opportunities to practice pharmacy within the safety net is one contributor to the recruitment and retention problem. Another factor is the lack of career advancement opportunities for pharmacists within the safety net as compared to the opportunities in the retail sector. While many safety net providers are able to offer entry-level salaries and benefits commensurate with retail employers, the equality changes for those pharmacists in the retail sector who move into management and gain salaries and benefit packages that significantly outpace those of their safety net colleagues. Professional networking and training opportunities are part of the overall benefits that retail pharmacists tend to receive; safety net providers, stressed for time and money, struggle to provide or enable their pharmacists to obtain the same professional development opportunities.

Safety net pharmacists are also challenged by their patients who differ from patients at non-safety net settings in that they tend to arrive at the providers' doors with more advanced health

problems. Safety net patients often delay health care for a variety of reasons including concerns about cost, long wait times, and feeling disrespected or discriminated against [10]. In addition, the safety net has a disproportionate number of chronic disease patients. As a result of safety net patients' delayed arrival and increased health problems, they require more medication. Pharmacists in the safety net, therefore tend to encounter a complex patient mix, for which their training may not have fully prepared them, and are required to procure a greater amount of drugs, increasing the burden on the already complex financial challenge.

The ethnic and linguistic diversity of safety net patients presents another challenge for pharmacists. Fifty-five percent of California's uninsured population is Latino, followed by 27% Caucasian, 11% Asian and Pacific Islander, 5% African-American and 0.3% Native American [11]. Twenty percent of California's population report difficulty speaking English; thus pharmacists must devote more time and may require translation assistance to communicate with their patients [12]. In addition, when counseling this diverse population, pharmacists must consider their patients' ethnic beliefs, health practices and possible use of complementary and alternative medications.

Unlike their colleagues (particularly those in medicine and nursing), safety net pharmacists are not often in leadership positions where they could utilize their dual expertise in quality care and cost containment at a more strategic and systemic level. This is particularly true in community clinic settings where pharmacists are relatively new to the staff and their potential leadership contributions to the system have yet to be realized. In some community clinics, pharmacists may be involved with strategy and planning, but they are rarely part of senior management. Pharmacists working in county health settings are more likely to be in leadership roles. On the whole, however, pharmacists do not often advance into leadership roles outside of pharmacy. As a result, safety net institutions miss an opportunity to leverage pharmacists' unique expertise as they struggle to address ongoing, critical needs.

Pharmacy Education

Pharmacists working in the safety net clearly encounter a unique set of demands, requiring knowledge, skills, and abilities beyond clinical expertise. Knowledge of drug procurement options for the indigent, creativity in juggling multiple priorities in a constrained practice environment, and cultural and linguistic competency are among the set of skills required for pharmacists to succeed at meeting the needs of their safety net patients. California schools of pharmacy provide their students with clinical skills, but do not uniformly offer their students the education and training they need to work in the safety net.

While many schools include information about issues related to safety net practice within their classes, this information is a minimal part of the overall curriculum and does not provide the breadth and depth of knowledge that students need to work successfully in safety net settings. In addition to classroom teaching, some schools also offer students opportunities to work with indigent patients at community clinics or county hospitals as part of their clinical rotations. Students, however, must seek out these opportunities, as they are not required as part of the clinical training.

One exception is the University of Southern California (USC), which implemented a well-organized, integrated, and grant-funded program focused on safety net and indigent care issues. The program introduces students to the safety net through multiple avenues, including class assignments, volunteer opportunities, rotations, and residencies. The

school partners with four community clinics, where students have the opportunity to work and some faculty members are based. Aside from USC's efforts, California schools of pharmacy are not adequately preparing future pharmacists to provide care to the growing number of safety net patients. Ultimately, pharmacists in the safety net must learn the skills they need on the job, a path that only the most tenacious and committed pharmacists are likely to pursue.

Organizing for the Future

The pharmacy safety net faces increasing challenges in the future, including a growing indigent population, increasing use and cost of drugs, and diminished funding. Pharmacists in the safety net, not only as individuals but also as a collective, will be an important resource required to help solve these problems. Although pharmacists within the safety net have begun to network, they do not yet enjoy the benefits of formal organization.

The first step toward developing a leadership network within the pharmacy safety net was indirectly taken in 1999 when Medicine for People in Need (Medpin) was created by the Public Health Trust, a project of the Public Health Institute, to implement a free drug distribution program resulting from a litigation settlement. The three-year drug distribution project ended in 2003; Medpin continues to provide training and technical assistance to improve access to needed medications and to assist safety net providers to develop, improve, and expand their cost-effective pharmacy services management. In the process, Medpin has served as an informal networking organization for pharmacists within the safety net, facilitating information sharing and opportunities for building relationships.

Medpin instituted a more formal networking structure through the creation of the California Safety Net Alliance for P&T Support. Comprised of physicians and pharmacists representing county hospitals, University of California hospitals, regional community clinic consortia, and county health systems (without hospitals), the committee reviews drug class monographs and develops clinical practice guidelines tailored to the unique needs of safety net patients.

Continuing efforts toward establishing formal organization among safety net pharmacists will enable pharmacists to impact both patients and their environment through education, policy and advocacy. By working together, safety net pharmacists have the opportunity to meet the challenges of their environment, which continually requires them to do more with less.

Recommendations

Preparing pharmacists to work in the safety net and establishing a professional network that could support them in their efforts would benefit both the pharmacists and the patients they serve. Combined, these two interventions – pharmacist education and the establishment of a formal organization – will enable pharmacists to apply their unique and badly needed expertise to the financial challenges of the safety net.

To prepare students to work successfully in the safety net, schools of pharmacy should incorporate required education and training regarding the safety net and indigent care into their regular curricula, including education about the specific needs of the population (e.g., advanced health problems, drug procurement, cultural issues), best practices in meeting those needs, and clinical rotations to apply new knowledge and practice new skills. Implementing required coursework and clinical practice relating to the safety net will serve a second purpose of increasing the recruitment of pharmacists into the safety net by introducing more pharmacy students to the safety net, possibly inspiring, motivating, and empowering

them to pursue employment in the safety net after graduation.

Establishing or enhancing a formal network dedicated to safety net pharmacists would facilitate communication, best practice sharing, and political power. Such an organization would leverage safety net pharmacists' collective knowledge and power, enabling them not only to work more effectively and efficiently on behalf of their patients, but also to create health care system change.

Conclusion

Largely driven by the aging population and the efficacy of drug therapy in the management of chronic disease, the increased use of pharmaceutical products has become the fastest growing, most dynamic part of the health care system. The same dynamism and potential benefits exist for the population served by safety net providers. Despite many skilled and dedicated pharmacists, the safety net faces a looming crisis, in which potentially fewer patients will have access to the care they need and the safety net pharmacy workforce will be unable to meet the needs of its patients. The growing number of uninsured and underinsured and the continually increasing use and cost of drugs are outpacing the expertise and size of the current safety net pharmacy workforce. In order to meet and overcome the continuing and expanding challenges of the safety net, pharmacy schools must train their students to work successfully in the safety net and a pharmacy safety net network must be established to bolster pharmacists' collective strengths and power to not only address but also change the current reality of pharmacy services for the safety net. Their patients' health depends on these changes as does their own future.

References

1. Institute of Medicine, *Hidden Costs, Value Lost: Uninsurance in America*. 2003, Institute of Medicine.
2. Charney, H., *Personal Communication.* 2005.
3. The California Endowment, *The Health Care Safety Net: Challenged Like Never Before, Needed More Than Ever.* Health...In Brief, 2004. **3**(3).
4. The Commonwealth Fund, *America's Unraveling Safety Net*. 2004, The Commonwealth Fund.
5. The California Endowment, *Holes in the Safety-Net: A Study of Funding Cutbacks and Safety-net Nonprofits in California (Report Highlights)*. 2004.
6. Siegel, B., M. Regenstein, and P. Shin, *Health Reform and the Safety Net: Big Opportunities, Major Risks.* Journal of Law, Medicine & Ethics, 2004. **32**(3): p. 426.
7. Dent, L.A., T.P. Stratton, and G.A. Cochran, *Establishing an On-site Pharmacy in a Community Health Center to Help Indigent Patients Access Medications and to Improve Care.* J Am Pharm Assoc (Wash), 2002. **42**(3): p. 497-507.
8. Richardson, K., *What is the 340B Program?* n.d., U.S. Department of Health and Human Services, Health Resources and Services Administration, Pharmacy Services Support Center.
9. Duke, K., Raube, K., Lipton, H., *Patient-assistance programs: Assessment of and use by safety-net clinics.* Am J Health Syst Pharm, 2005. **62**(7): p. 726-31.
10. Becker, G., *Deadly Inequality in the Health Care "Safety Net": Uninsured Ethnic Minorities' Struggle to Live with Life-threatening Illnesses.* Med Anthropol Q, 2004. **18**(2): p. 258-75.
11. Dorn, S., *Distinctive Features of Califorinia's Health System: A*

California Perspective on National Reforms. 2005, Economic and Social Research Institute: Washington, D.C. p. 1-50.
12. Shin, H., Bruno, R., *Language Use and English-Speaking Ability: 2000*. 2003, U.S. Census Bureau.