



The Safety Net Community Speaks about the Drug Distribution Project

What has been the most positive impact of the DDP for your clinic's patients or staff?

"The DDP gave us an option for patients without money."

"[The DDP] improved continuity of care. Our staff felt good..."

"The cost savings from the DDP give the county a chance to serve more patients."

People got medications that otherwise wouldn't have been available to them. It improved continuity of care. Our staff felt good to be able to provide that kind of care.

The DDP provides a window of opportunity to use new and expensive products that were not on the clinic's formulary and provided value to patients. The DDP also offsets pharmaceutical expenditure costs. While the DDP drugs account for only a small portion of the 40,000 prescriptions the clinic dispenses annually, the dollar amount saved is considerable.

The cost savings from the DDP give the county a chance to serve more patients.

The first impact is allowing more open access to medications. With the DDP, in combination with patient assistance programs, we can provide the entire range of psychiatric medications. The physicians can select the best drug for the patient's treatment. The second impact is that it has temporarily insulated our county's budget from the impact of costly new anti-psychotic medications.

The DDP has been enormously beneficial to us. Our DDP credit overstates by about 50% our actual acquisition costs for those drugs. But even if you look only at our replacement costs, we've been able to save 10% on our overall pharmaceutical budget. For a county that is as financially challenged as we are, it's been an enormous benefit.



The DDP gave us an option for patients without money. Pharmacy costs are so expensive that to be able to offer medications to patients was very rewarding. We received positive feedback from patients. They really, really appreciate it. The staff could feel good about what they were doing.

“It was difficult when the clinic ran out of a DDP product and had to change patients’ prescriptions.”



Photographer: Michelle Vignes

“When there are no more DDP drugs, we’ll just have to work harder applying to PAPs...But how many others will also be doing that?”



“I’m anticipating an 18% increase in pharmacy costs.”

Are there aspects of the DDP that create difficulties?

It was difficult when the clinic ran out of a DDP product and had to change patients’ prescriptions. Sometimes there was a coverage gap for specific drug categories. We worked with physicians to get their buy-in and shape their prescribing habits. For example, we alerted them when the [DDP] Claritin supply was exhausted, telling them that Allegra would soon be part of the DDP.

Inventory segregation, tracking and record keeping required significant staff time. I do not have the resources to hire extra people.

Clinic staff need frequent reminders to carefully assess patients’ DDP eligibility. One problem is training staff to handle DDP drugs in a different way. Because we don’t “purchase” DDP drugs, we can’t enter them into our computer system in the usual way.

It’s a problem to be placing order requests supposed to cover a whole year, instead of doing continuous ordering as we do for drugs from other sources. This non-continuous ordering is really a

problem when I receive drugs with short expiration dates. I couldn’t use all of the DDP drugs before their expiration date, and I hated to waste them.

When the DDP program first started, the list was not as varied as it is today and did not have some of the new products that would come up at P & T meetings. I did not want to add or change a therapeutic treatment not knowing exactly how much free product I could get, if any. The drug additions this past year were ‘biggies’ for me, in particular PremPro, Ultram, Topamax, Lotensin, and Protonix. I wish they had been available earlier in the DDP.

One of the interesting challenges for a facility like ours that has both the DDP and an established patient assistance program (PAP) was deciding whether to order DDP drugs that were also easily accessible through the PAP. For example, Neurontin is very high volume for us and very accessible via the PAP. “Should I spend my DDP credit on Neurontin or use it on another drug?”

What will your clinic do when the DDP ends?

That’s scary. Unlike the DDP, there is no uniform way to access PAPs. With our limited budget, our priority is hiring a clinical pharmacist. We don’t have the resources to hire a dedicated staff person to manage PAPs. We are mostly using Pfizer’s Sharing the Care program.

The huge cost advantage of the DDP will be almost impossible to fill without a significant increase in our pharmaceutical budget. I’m anticipating an 18% increase in pharmacy costs.

We haven’t used PAPs extensively, although I now have one full-time staff person dedicated to managing PAPs. We have achieved \$500,000 in savings through the PAPs, but that doesn’t come close to replacing the DDP drugs. My fear is that pharmaceutical companies are looking to step away from their PAPs and focus on these new discount cards.

The financial impact will result in major changes. Under consideration is a possible reduction in clinical services to offset increased medication costs.

The bad news is this program has an end. If there is anything I can do with Medpin to keep this program alive, i.e., encourage future participation by the pharmaceutical industry, please let me know.

We’re already preparing for that. Since 1998, we’ve been working aggressively with PAP programs. Our costs will definitely go up. Most of the patients we see are very ill and can’t function but it takes 6-12 months to get them on Medi-Cal/State disability. The DDP and PAP drugs are critical during this time frame.

When there are no more DDP drugs, we’ll just have to work harder applying to PAPs, or target the most cost-effective ones for us. But how many others will also be doing that? There has to be a ceiling on the amount of drugs that companies will give through PAPs. What’s going to happen is they’re going to make the requirements even tougher. And who’s going to lose--again? It’s the patients!

What message would you give to the public about medications for indigent patients?

Appropriate use of medications is the most cost-effective intervention. It reduces both morbidity and mortality. Use Medpin as a clearinghouse to administer programs to serve indigent patients. This would add an element of uniformity to the whole process.

Mental health services are at the bottom — underfunded and the first to get cut.

Applying for PAPs on an individual patient basis makes it more difficult to track and store the prescriptions. A centralized program like the DDP simplifies tracking, monitoring and documenting that drugs are dispensed to patients who meet the eligibility criteria. If there were a certain percentage for indigent care and a uniform way to access these drugs, that would make a significant difference.

Drug companies need to develop bulk replenishment programs and simplify the application process. They need to streamline and automate to enroll large numbers of people from county programs serving indigent people.

We have rated the companies from 1 to 10 on how easy it is to get PAPs. I'd ask some companies to make fewer demands on patients, and all to have the same PAP forms and eligibility criteria.

The DDP provides a simple and straightforward system to access free drugs for our indigent patients. We have a system in place to screen for financial eligibility and a mechanism for tracking our dispensing to make certain that the DDP drugs are going to eligible patients. We review our drug utilization and select DDP drugs that we know we can use and that would not otherwise be available to our patients.

Before Medpin, nobody was talking about these issues. Thanks for what you've done!

Drug companies need to "share the care." Clinics do more than their fair share, so now pharmaceutical companies must make an effort to help indigent patients.

Health care costs are spiraling out of control. If we don't develop a meaningful way to meet the medication needs of indigent patients, government regulation Canadian-style or a single-payer system may be inevitable.

I really like the user-friendly DDP ordering system. In addition, the DDP is centralized, and uses an existing system [of in-house pharmacies or licensed drug dispensaries] to deliver drugs to indigent patients.

Legislative bodies need to pressure the drug companies to make changes to their patient assistance programs to improve access to free medications for indigent patients. One of the major companies' PAPs requires monthly reapplication; our doctors won't do it. Most of the PAP programs are administered through a company that adds another layer of bureaucracy and costs.

Support national health insurance.

Regardless of citizenship, medications need to be available to all. Treat and consider all patients from a public health perspective.

There is an enormous and growing need for free drugs for indigent patients. Discounts are not sufficient. In my heart and in my mind, I'm sure we can provide pharmaceutical care for all Americans in need. I'm sorry that it required litigation to force companies to provide products to indigent patients. We've clearly identified the need and now we must set a budget to serve those without access to medications. Things have to change. We're not talking about luxury; we're talking about necessity.



Photographer: Michelle Vignes

"Drug companies need to develop bulk replenishment programs and simplify the application process."

"A centralized program like the DDP simplifies tracking, monitoring and documenting that drugs are dispensed to patients who meet the eligibility criteria."

"Legislative bodies need to pressure the drug companies to make changes to their patient assistance programs to improve access to free medications for indigent patients."



505 14th Street, suite 810
Oakland, CA 94612

Phone: 510.302.3300

Fax: 510.444.8253

Email: info@medpin.org
www.medpin.org

The Pharmaceuticals and Indigent Care/ Drug Distribution Project (DDP) of the Medicine for People in Need (Medpin) Program administers the drug distribution portions of litigation settlements involving 24 major pharmaceutical companies. As a result, the DDP has to date distributed \$100 million worth of selected brand name drugs at no cost to California community clinics and county health systems requesting those drugs for their indigent patients. As the DDP enters its final year, Medpin staff conducted phone interviews with a diverse selection of DDP participants to hear their experiences with and views on the DDP and related issues.

Medpin thanks all the companies, clinics, and individuals who have helped the DDP operate during its first two years. Special thanks to the following people who took the time to be interviewed about the DDP and whose comments are excerpted above: *Jenan Almansour, MD, La Maestra Family Clinic; Jan Edwards Aston, RPh, MPA, South Indian Health Council; Douglas Del Paggio, PharmD, MPA, Alameda County Behavioral Health Care Services; Scott Drugan, PharmD, Los Angeles County Pharmacy Services; Denise Fairhurst, Mt. Shasta Medical Clinic; William Mastin, RPh, San Diego County Department of Health Services Pharmacy; Gordon Misaki, PharmD, University Medical Center Pharmacy, Fresno; Inhee Park, RPh, Los Angeles County, King-Drew Medical Center Pharmacy; Charles Vaughn, RN, Eureka Community Health Center; Geraldine Vayson, PharmD, West Oakland Health Center.*

Photos received from Lifelong Medical Center in Berkeley, CA.

May 2002

Medpin is a program of PHI

