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Questions-and-Answers from “Building a Meds to Beds Program” Webinar

Presentations by:

- **Ohio State University Medical Center (Columbus, OH) - Danielle Blais, PharmD, BCPS-AQ Cardiology and Megan Marchal, PharmD**
- **St. Vincent’s Medical Center (Bridgeport, CT) - Marit Planton, BSN, RN, Gina Mozzicato, PharmD, Amy Kurzatkowski, RPh, and Yeo Jung (Sally) Lee, PharmD**
- **Fairview Hospital (Cleveland, OH) - Anthony Kitchen, RPh, and Michael R. Hoying, R.Ph., M.S.**

Q: How are you handling same-day PCI discharges for cases that occur late in the day?

A: Ohio State- For our same-day PCI program, we use a radial first approach for those patients. At the beginning of the day when the cases start, the patients are flagged as a potential for same-day PCI. That way the entire team taking care of them knows that they’re a possible candidate. At the end of the cardiac cath once the patient has a stent, if he/she is still a candidate for same-day PCI, the nurse practitioner knows to start sending the prescriptions over to the outpatient pharmacy. Ideally by 2 pm, the patients that would be going home the same day would have the prescriptions ready so that the medications are delivered at time of discharge. For patients that get discharged later, we have a delivery service so the medications could be delivered to the patient’s house the next day. However, the majority of the time we’re able to capture those prescriptions early enough in the day so that they get delivered before the patient is discharged.

St. Vincent’s- Most of our prescriptions are the same day. We do deliveries between 9 am and 5 pm and usually request that the provider notify us about an hour ahead of time. That allows us to work out any issues and coordinate delivery.

Fairview- We operate in the same way as St. Vincent’s.

Q: If you’ve identified reductions in readmission rates, how are you able to tease out the impact of this program versus any other efforts that may be going on concurrently at your institution?

A: Fairview- It’s difficult to tease out because there are so many efforts trying to pinpoint services that reduce readmissions. For example, we have a high risk pharmacy program that compliments the program. We have data surrounding those patients that are high risk that did not have pharmacy services at admission, daily or at discharge versus those that did.

Ohio State- It is difficult to tell which intervention is having an impact because there are so many moving parts with reducing readmissions. One thing we’ve focused on is when we go back and look at readmitted patients, we try to make sure that there are no medication related issues that could potentially have contributed to the readmission. Going forward, we will do a drill down on those patients to see which factors could have contributed.

Q: How many of you are using programs that have 340B pricing to facilitate Meds to Beds?

A: St. Vincent's- Our hospital is not 340B eligible.

Fairview- Fairview Hospital is not 340B eligible. I am the director of Lutheran Hospital and they are 340B eligible. We use it because it is a way for us to have more qualified 340B prescriptions, it's a benefit to the patient, and it helps the institution with revenue.

Ohio State- We are considering the idea of 340B pricing and currently using our resources to dive further into the process.

Q: Have you seen any distinct changes in HCAHPS scores since starting these services?

A: St. Vincent's- We did mention HCAHPS scores in our presentation, but unfortunately response rates are low. We're going to encourage our patients to complete more HCAHPS surveys, but we don't know yet if this is a reliable source of data to see the effectiveness of our program. We do hope to increase those scores through patient education and promotion of survey completion.

Fairview- With HCAHPS, there are a couple domains that can be affected; transition of care, communication on medications and discharge process. We have seen some improvements in discharge process. Communication on medications is a bit like temperature, it goes up and down, but overall the direction of the curve has gone up. Again, it's a challenge to determine if Meds to Beds has impacted those scores, but we can definitely see in the testimonials and comments on HCAHPS that we do think it's playing a role.

Q: Have you looked at the cost of extra staff needed, the resources, etc., compared to the reimbursement costs? Have you found this program to be cost effective?

A: Ohio State- Currently with our Meds to Beds program, we have not increased the number of resources at all and therefore it's difficult to tell. For example, if we've only done 32 patients from November to June and we discharge 30 patients with AMI per month, then there are a lot more patients that we could be providing Meds to Beds to. We are looking into how we are going to accomplish this and what resources will be needed.

Fairview- We've looked at it and determined that we can break even on our discharge technicians if we do at least 30 prescriptions a day. The other staff members, for example pharmacists, are incorporated into the retail pharmacy, so we do not have to add another pharmacist.

St. Vincent's- We are in a similar situation. We use our outpatient staff to fill the prescription but we utilize the pharmacist on the floor, as well as the residents throughout the hospital and students that rotate through both the community and hospital rotations, to work with the Meds to Beds program.

Q: A problem often faced by small rural pharmacies is that they may not carry the medication and need a day or two to get it in stock. How would you suggest dealing with this issue?

A: St. Vincent's- There are times when we don't have medications as well. What we try to do in order to prevent this is to work with the providers ahead of time by requesting a list of medications they normally prescribe. This collaboration is very important.

Fairview- This can be a challenge. We believe you have to make a commitment to the program. A good initial approach would be to look at the top drugs you use (for inpatients) for top diagnostic groups (e.g. CHF, COPD, AMI, and pneumonia) and assure you have those drugs in stock. Second, if you have

prescriptions for different drugs that are not in stock but are in the same drug class that you have an offering (formulary drug), have your pharmacists contact the physician in an attempt to change to a stocked medication. Third, leverage generics that are on discount programs (e.g. \$4.00 formulary at CVS), drugs you have sample vouchers for, or other free drug programs to steer prescriptions to “stocked drugs”. Last, if you are not able to fill the prescription, either borrow (if feasible) or return the prescription to the patient and let them know you have called their home pharmacy, which should be in the electronic health record (EHR), and they have it in stock.

Q: Do any of your programs have services available for obtaining prescribed medications after the free 30-day supply has been exhausted?

A: St. Vincent’s- We do not have an initial free 30-day supply on most medications. If manufacturer savings or coupons are available, we use those for a free 30-day supply. For patients who are uninsured, we work with the case managers to “bill” under our charity funding. We have an off-site charitable pharmacy, the Hope Dispensary of Greater Bridgeport, which is part of the Dispensary of Hope (from Nashville, TN) and we utilize their formulary during the initial discharge process if needed. Beyond these first fills, our charitable pharmacy will try to enroll patients in Prescription Assistance Programs.

Fairview- We offer our patients a number of options to receive the benefits of reduced prescription costs. If a patient doesn’t have insurance and wants to come back to our pharmacy, our pharmacists will use available discount cards (e.g. NeedyMeds Discount Cards) to try to get the best price. In our programs, the qualified patient can receive discounted co-payments for 12 months. For patients seen in our “internal medicine” and “family practice” clinic, Fairview Hospital runs its own charity care program that discounts prescription costs based on the patient’s financial situation.

Ohio- We do not provide a free 30-day supply unless the patient is uninsured or underinsured for a medication. If a patient falls into either of those two groups, he/she is enrolled in our medication assistance program, in which we work to get the patient enrolled in a manufacturer sponsored program or we find the least expensive place for the patient to obtain the medications. In select cases, we will provide a medication after 30 days, but only if the medication is lifesaving (no manufacturer coupons available and is expensive).

Q: Can St. Vincent’s share the internal results of the research mentioned in their presentation?

A: St. Vincent’s- We are just starting the study as we recently received IRB approval. If you’d like to know more about the current study details, please email YeoJung.Lee@stvincents.org .

Q: What happens to the remaining refills? Do the patients leave with a script or will their primary pharmacy have to transfer the refills?

A: St. Vincent’s- Our discharged patients usually require a follow-up and the hospitalists/residents at SVMC do not normally prescribe refills. If they do, the refills can be transferred to the patients’ primary/regular pharmacies. If the patient lets us know what pharmacy he/she uses, we can call that pharmacy and transfer the prescription(s). If they do not, the pharmacy can call us when the patient needs their medications again.

Fairview- The prescription is legally ours after we fill it. Most discharge prescriptions do not have refills; those are written usually during the patient’s follow-up visit (with their primary practitioner post-discharge). We will freely transfer refills to their home pharmacy. We haven’t been extremely effective, but we will encourage mail order (we have that service at the CC) to continue to support their adherence.

Ohio- We work with the patient to determine what works best for them. The outpatient pharmacy will receive the full script and follow up on Day 9 and Day 25 to discuss where the patient would like future fills. OSU outpatient pharmacy will coordinate the transfer of all refills if the patient wishes to fill locally. We try to avoid giving the patient written prescriptions because they tend to get misplaced.

Q: What are the pros and cons of harnessing your inpatient versus outpatient pharmacy in this program?

A: *St. Vincent's-* Our Outpatient Pharmacy is the only source that can provide patients with their discharge medication(s) in our hospital system. We utilize our inpatient pharmacists to help with the Meds to Beds counseling.

Fairview- The first pro is that the program is aligned with our organizational goals. Second is cost mitigation, which allows us to capture revenue (instead of trying to cut costs) that is leaving our system. Third is readmission reduction, which is obviously not the “one” factor that can “fix” this issue, but it can contribute to a program’s success. And last is adherence via insurance coverage because our pharmacists can more efficiently contact prescribers (page/call before they leave the hospital) to resolve insurance coverage issues. Also, we can assure that the patient is engaged with their pharmaceutical care and if there are issues with complexity of the regimen (e.g. they don’t believe they can manage), etc., these can be resolved before the patient leaves the hospital.

The biggest con (it is more of a challenge) is changing the “culture” of inpatient healthcare teammates to look at transition of care. Some staff view this as “coordinating” one more step that they may see as a barrier in their process rather than looking at the benefits that the program could have for the patient. The program requires a daily advocate to continue to keep this in the forefront of our healthcare team as they think about discharging a patient. Again, this is more of a barrier, but for many factors (including social), the discharge process is not a structured event. Meaning, discharging the patient can happen at any time and usually appears to be a rushed process.

Ohio- There are many pros, including: 1. Both have access to the EHR and there is one central location for information and coordination of patient information. 2. The outpatient pharmacy understands the billing of loading and maintenance dosing of medications. 3. Manufacturer coupons are automatically put on the patient record so that the inpatient pharmacy doesn’t have to fuss with searching for information. 4. Day 9/25 follow up calls allow the outpatient pharmacy to screen for ADE and if identified, has the ability to immediately coordinate patient switching medications with no break in therapy. 5. Transfer of scripts to the local pharmacy if the patient wishes.

Some cons include: 1. Patients like their home pharmacies and want everything in one place. 2. Timing of medication delivery can slow down the DC process. 3. Patients do not always have ways to pay for their medication when they are admitted to the hospital.

Q: Do you provide home delivery services? Do you have multiple acute care sites and courier medications to other sites without an output pharmacy?

A: *St. Vincent's-* Our site does not deliver to patients’ homes. We do have a Behavioral Health site about 15 miles away, which sends us prescriptions the day before, we prepare them and then use our current courier service to send the medications the following day. The biggest challenge is the financial piece for payment because the patients that normally use this service are Medicaid or charity patients.

Fairview- We can do mail order for refills, but not the original fill. We initially did this many years ago, but the State Board of Pharmacy in Ohio ruled against it. I believe the rules would allow it now, but due to the challenge of timing of the discharge process, our system has implemented this at each local hospital. The model is different based on the size of the individual facility in our system. Larger hospitals have retail pharmacies, while smaller hospitals may run it out of their inpatient pharmacy – e.g. “closet” retail pharmacy (separate license, separate stock).

Ohio- OSU outpatient pharmacy delivers same day locally with courier service to a patient’s home or it will continue to send refills to patients for free via UPS next day delivery. There are multiple hospitals within our health system and all of them do not have an OSU outpatient pharmacy on sight; therefore the courier will deliver medications to the other hospitals which are within 7 miles of each other.

Q: Can you share how you're documenting which medications are being filled by your team?

A: *St. Vincent’s-* Our inpatient and outpatient systems are different. When the pharmacist completes a Meds to Beds, he/she documents this into the inpatient hospital system, Cerner. When we fill medications for discharge, we utilize the outpatient pharmacy system and input the prescriptions as “Discharge” (as compared to “Waiting” or “Delivery”). Once the labels are printed for the medications, we label a “Meds to Beds” form for the patient’s signature and file this information in chronological order.

Fairview- This is done through Cerner. We also have two discharge pharmacy technicians that drive business to the program. They are responsible for tracking how many prescriptions each unit generates. We use this data to motivate pharmacy students (they introduce the program to all new admits), pharmacists, nurses and nurse managers to continue to utilize the service.

Ohio- Telephone encounters are documented in the patient chart listing the medications that are expected to be delivered to the patient. For deliveries after discharge, similar documentation is completed for refills. There are standard templates which are used to document this information in the EHR.

Q: Do you provide service on the weekends?

A: *St. Vincent’s-* The Outpatient Pharmacy at SVMC will pilot being open on Saturdays, but will not be doing Meds to Beds deliveries due to staffing limitations. We do not have any floor pharmacists and will only have 1 pharmacist and 1 tech in the Outpatient Pharmacy on Saturdays.

Fairview- We have hospitals in our system that do provide the service on the weekend – these hospitals have a “Closet retail pharmacy” in their inpatient. We currently provide this service through our retail pharmacy and do not provide the service on the weekend.

Ohio- Currently we do not have services available on the weekend because the OSU outpatient pharmacy is off sight from the main medical center. Within the next few months, those hours will expand to include weekends.

Q: Are your programs intended to serve all patients who are receptive or are you trying to target primarily patients deemed at high risk? If you are targeting a specific patient population, can you define your target population?

A: *St. Vincent’s-* We are looking into targeting specific high-risk patient populations, but at this point, we are doing Meds to Beds for any patient within the hospital being discharged home.

Fairview- Our program is intended to serve all patients. That being stated, it is evolving to try to convince patients with a specific diagnosis (e.g. CHF) to use the service.

Ohio- Determining which patients should be sent home with Meds to Beds is a work in progress. As this is a new process, there are not enough resources to deliver medications to all patients so we are working on developing a tool to identify those patients at high risk for readmission. There are also other factors such as bundled payments, which are driving which patients receive Meds to Beds.

Q: Is a pharmacy order for follow-up a part of your order sets for the AMI (STEMI and NSTEMI, and PCI's), or is it nurse-driven?

A: *Fairview*- It is a team effort; however the pharmacy searches for patients to follow-up with. Our Pharmacy Discharge Technicians directly interface with the Bed Control Nurse to be aware of potential discharges. It is a combination of the Discharge Technician, pharmacy students, decentralized pharmacists and nurses to generate business. The Discharge Pharmacy technician is the top driver.

Ohio- Currently, there is nothing in the order sets for Meds to Beds. This is mostly pharmacy driven. There are transitions nurses who call some of the patients at home to see if they have their medications, any questions/concerns, and a follow-up appointment scheduled. Streamlining these phone calls and knowing who is calling these patients at home is a work in progress.

Q: Any advice on working with a retail pharmacy to fill Rx?

A: *St. Vincent's*- A hospital-owned pharmacy would be the ideal way to go to prevent any additional issues. With that being said, if your hospital does not have or does not plan to start a pharmacy, working with an outside pharmacy would be beneficial. Walgreens is trying to do something like this. Utilizing independent pharmacies would also be a good way to go.

Fairview- Our organization feels that we can connect with our patients better and meet our organizational goals by having our own pharmacy. Working with a retail pharmacy is a reasonable thing to evaluate if you don't think you can secure resources to support the program.

Ohio- The advantage of the OSU outpatient pharmacy is that it has access to the EHR and connections to the providers writing the prescriptions. We also have the ability to communicate protocols and special details about discharge medications.