Speaker 1:

Okay. I think we're about to get started as people are joining and I'm sure we'll have some more attendees come in in the next couple of minutes. But happy Friday and welcome to another installment of our Shields Health Solutions pharmacy exchange where we're continuing to focus on COVID-19. For those of you who haven't joined us in the past, this is intended to be a very quick and casual review of both facts and experiences for you to apply to your health system on specialty practice. The webinar is being recorded and the recording and the slides will be available shortly, probably early next week. Additionally, we have a number of tools available regarding some of the topics that we talk about. And we also send out a weekly policy briefing. So please reach out if you're interested in receiving either of those things or you'd like to learn more. So today you're going to hear from my team the health system strategy team here at Shields. I'm Erin Hendrick and I'm joined by Chris Paciullo and Steven Davis. We're extremely lucky to have Gary Kerr join us today as the CPO for BayState Health. He has led the COVID-19 action plan for his department and he's going to share with you what he has done and observed when leading these efforts at BayState.

Speaker 1:

But I'm going to kick it off with some basic facts to set the stage on the COVID-19 journey. And I apologize because it's actually rather bleak where we're starting today. So as of this morning, there are nearly 1.5 million confirmed cases of COVID-19 in the United States. This is up from 25 up 25,000 from yesterday and deaths are nearing a hundred thousand, which are up from about 1,300 from yesterday. So as many of you know, these numbers have been slightly variable based on how different states are reporting. So they do bump around a lot, but they do continue to go up.

Speaker 1:

As we look to the country, 37 of our states have eased at least one social distancing role. Twenty-nine still have their stay at home orders intact as originally put forward. But these have been implemented or eased or lifted in about 16 of the States. A quarantine for travelers remains in place for seven or for 20 States and in 14 states the original non-essential business closures remain intact. So then as we look into healthcare early prescription refill rules were enacted in 18 States with no action in 33 States. And you'll see some of that when we go into the data that we've seen in terms of health system specialty pharmacy.

Speaker 1:

The payment of premiums for health insurance has been extended in 11 States for any reason. And in five states for COVID-related reasons only. And then 12 states have opened up their marketplace for special enrollment to purchase health insurance. As of March 15th, approximately 39 million people have filed for unemployment, many of those in low income brackets. And so as we're nearing 10 weeks or so into the crisis, those employees will for COBRA will be likely falling off of that this summer. And it's anticipated that we're going to see some large surges in Medicaid and self-pay patient populations. Hospital margins have been an all-time low, or currently in April, they're running at negative 29%, not down 29%, but negative 29% which is a 282% decline from the usual run rate. And finally over 250 hospitals have furloughed or terminated employees due to this current financial crisis. One bright spot is health system owned specialty pharmacy has and continues to demonstrate significant resiliency, with dependable and growing income for our health system partners as compared to January and February run rates.

Speaker 1:

We've continued to see revenues increase. This is despite a precipitous decline in specialty clinic visits and new patient diagnoses. So, despite the fact there are less patients coming into hospitals, revenues have continued to increase. We will cover telehealth in a second. But as we look forward, we certainly can predict continued strength in specialty pharmacy revenue. But the pattern of growth may be very different than what we had previously anticipated. It still remains a little bit unclear how specialty is going to continue to grow, although we know it will. Just what pattern and where these patients are going to be coming from and how we're going to see them remains in question. So what did we do or what do we look out for? Well, some of the questions we need to think through include when our clinic volume is going to return. For some it may appear to be significantly improved over April.

Speaker 1:

When we look at our health system partners, there may numbers that look much better in terms of total specialty visits. That said they're still way down and it's unclear how we're going to budget visits for the next 12 months with our health system partners. And we know that these volumes are down 50% in many of our partners. And then some of the health systems that we talk to every day, there certainly is a deferral of care impact. As we discussed in our last webinar, there's clearly a deferral of needed care and it's thought to be that one in three patients are likely going to defer treatment for an emerging problem. So this is going to be a huge issue for just the population in general and also for us as health system partners and health system pharmacists.

Speaker 1:

We're going to see sicker, more complex patients which will play into the management of these patients as well. So you know they may not be able to go on the step therapy that's recommended because they'll have to skip a few of those steps and or their window for a cure may have been missed because of their lack of being seen for a long time. Finally, as I already mentioned, there's a payer impact, so with over 36 million unemployed in COBRA coverage during COVID, or self-paying. Medicaid is anticipated to take a huge strength swing, so going up and then health systems are going to have to try to figure out how to continue that. It's always been an unequal balance of payers and managing how reimbursement happens, but really looking at that and trying to shift that to the positive.

Speaker 1:

Switching a bit into tele-health. Is this our new normal? As many of you know telehealth wasn't really used before the pandemic. And usually for new services, not existing services. That said this is rapidly expanded during the crisis. Previously one of the reasons telemedicine wasn't used is there were a lot of restrictions and not a lot of payments. The good news is this has changed a bit and so the federal government has focused on loosening restrictions on telehealth and Medicare beneficiaries are probably the ones that it's easiest right now to provide for them via telehealth because Medicare will allow you to provide in any state to receive care. HHS has waived the enforcement of HIPAA for telemedicine to an extent. So it's a walking a looser line in terms of how to make sure that communication is as secure as it previously was.

Speaker 1:

The DEA has listened to requirements on e-prescribing of controlled substances on state level Medicaid's programs have expanded telehealth and relax some of the provider licensing rules. And then many of States are also mandating that fully insured private plans cover and reimburse telemedicine services at an equal level that they would have to in-person service. That being said, many of our commercial insurers haven't necessarily fully followed suit. The payments still remains a bit unequal, although there certainly is improvement there. And then how systems have rapidly tried evolve to make sure that they can meet this. And as you all know changing and adding tele-health is a Herculean effort for health systems. This is a very different process, a very expensive process, and required moving very, very quickly. In many of the health systems that we work with have done a very good job of doing this, but there were no processes and procedures three weeks or three months ago.

Speaker 1:

And so we're creating them on the fly. Additionally, patients do require a device to receive these telehealth visits. So there remains some socioeconomic disparity in terms of their true impact of telemedicine on our patients. And finally, some providers have noted that patients are not showing up to these visits. So patients are showing up to telehealth visits, you know, partially clothed and then intoxicated, not really ready for these types of visits. And then finally, in our specialty programs, we know that many of our disease States require either radiology or palpation or injection, other things that are very, very difficult to do from afar. And so while a lot of primary care visits and some of our specialty visits can be done remotely, many of them will require a patient's coming back into the health system.

Speaker 1:

Finally, the last step that I'm going to cover before I hand it over to Chris is HERSA. And so this is just a quick update. We talked about this before, but HERSA has announced that it's changing their rules upon requests to allow sites that qualify to immediately enroll in the 340B program. They've made some other changes as well. But the one thing that we just wanted to update this group on is we definitely see action happening here. So every Friday a new list is released of sites that have applied or requested this allowance and HERSA definitely has been responsive to that. And so certainly we're always here from a Shield's perspective. If you have any questions on what we're seeing out there, but both from a child site and a contract pharmacy site perspective, we are seeing allowance of early entry into the program. So Chris, I'll hand it over to you now.

Speaker 2:

Great. What I want to talk about a little bit today was thinking about specialty pharmacy post-COVID and this new reality that you keep hearing in the news and realizing that as Erin said, you know, a lot of States have opened up, are in the process of opening up and we're going to be faced with a new normal and what does that look like? So expanding on what Erin already talked about with telehealth visits and seeing more and more telehealth visits. I'm thinking about that as it relates to specialty pharmacy. So a lot of specialty pharmacies will enroll patients when they come into clinic and you have a physical one-on-one contact point with that patient. But as that goes away, how are you going to operationalize enrolling those patients when they come in for a telehealth visit? Do you have visibility into the appointment scheduled for telehealth visits?

Speaker 2:

How are you going to do counseling? Do your pharmacist or pharmacy technicians have access to that same tele-health software where they can do counseling? They can do some of the touchpoints with the same software. There might be some limitations with technology that might have to be put into place depending on the site. We always have to think about language barriers. So how do you get a translator involved with a patient who needs those services? With telehealth, a lot of us are very familiar in the clinic or the hospital settings with the colored phones or iPads. What do you do and what are the logistics around that? And also is Erin and Steven talked about the 340B implications around telehealth visits and counting that as an encounter. The other thing we're seeing is a lot more shipping.

Speaker 2:

People are starting to leave their homes a little bit more, but a lot of people have just realized that the convenience of shipping, whether it be their medications or groceries, is a lot more convenient. And not having to go beyond their front steps is kind of nice. So, we’re going to definitely see more and more with that. More patients who elect to have their medication shipped, even if they can come pick it up or pick it up at clinic. They just want to shift so they don't have to think about it. Thinking about the projections and increased workload around packaging costs considerations. If you're shipping a little bit now and able to buy a little bit of shipping materials here and there, you might be looking at buying more in bulk in the future. And also realizing that for those of you who are currently at a 3.0 that 4.0 is coming and has new requirements around shipping, both for cold chain as well as room temperature.

Speaker 2:

And making sure that you're looking forward to that and what you're going to have to do to change your practices. The other thing I wanted to talk about is a remote pharmacist work. You know, as a pharmacist working from home when I was in pharmacy school, it wasn't a thing. It wasn't a thing 18 months ago or a year ago, but suddenly we see a lot more pharmacists working from home for the time being and a lot of pharmacists, and honestly other industries thinking, do we really need to have an office? We really need to have people come in. So the projections of the COVID-19 may have some long lasting effects on being able to allow pharmacists to work from home doing some counseling, those non-medication-touching kinds of work.

Speaker 2:

So with that you have to think about infrastructure. What kind of equipment can you use the security with around that equipment? Making sure that your pharmacists have access to broadband. How are they going to do phone calls, a service that reroutes their phone lines to have a number that comes up from the hospital conferencing software, the telehealth software. It's things to think about that you're probably doing a little bit right now, but things that definitely you're going to see more of in the coming months to years.

Also in workflow you know, not being shoulder to shoulder with providers. How are you going to communicate with providers? Is it through in-basket messaging? Is it through phone calls? Is it through secure text? How are you going to do it with patients too. The same issues arise? I think it's a great use as a recruitment tool. I think that if anybody was offered a clinical pharmacist job where they'd get to work from home, I think you could get some really great talent into those positions. And maybe even from across state lines, depending on your board of pharmacy and, and their regulations around whether it's a nonresident state or something that you can get a nonresident permit for.

Speaker 2:

And with that, I'll shift over to Steven and financial impact.

Speaker 4:

Thanks, Chris. The American hospital association released a report that forecasted the financial impact of COVID-19 on hospitals and health systems in the United States during that four month period between March 1st of 2020 to June 30th of 2020, their report estimated that a total of $202.6 billion in losses, which is an average of 50 billion in losses per month. The report also stated that most health systems were already facing financial pressures prior to the pandemic. Some of the previous financial pressures were due to low payment rates from government payers as a result of the pandemic health system measures to increase the personal and public safety across the country while also attempting to preserve PPE health systems council, most of elective surgeries, 90 central medical surgical and dental procedures. These measures have resulted in adjusted discharges, which is a measure that accounts for both inpatient and outpatient services decreasing by 13% from the previous year, and as Erin mentioned earlier, over 200 plus health systems have furloughed staff to help offset the severe financial damage due to the clients and patient volumes.

Speaker 4:

Several health systems have had to make the difficult decision to permanently reduce their workforces as well. Due to the economic downturn, there's been an increase in the number of uninsured individuals. There's been an increase in Medicaid enrollment and also an increase in individual coverages through to state and federal marketplaces. COVID-19 has certainly had an impact on patient and procedure volumes within hospitals. One report stated across all service lines in every region of the country. The number of unique patients who stopped care in a hospital setting decreased on average by 54.5%. What's more concerning is that clinical care for patients with life threatening conditions and patients with chronic conditions have also decrease. Healthcare providers continue to raise concerns that patients are foregoing important disease state management, which can further jeopardize their health. I think this is a good time to transition to Gary Kerr as he discusses how his team at BayState health are continuing to manage the patient's specialty pharmacy needs from the hospital.

Speaker 5:

Thank you, Stephen. Let’s jump right into this. So most importantly to you. Before I set this up, I wanted to talk a little bit about where we are here located geographically and kind of our scope and our history to date. We're located 90 miles West of Boston and 90 miles East of Albany. We're a four hospital IDN and the anchor really is the academic medical center of BayState Medical Center, which is around 800 beds. We are in our seventh year as a specialty pharmacy. March and April were our busiest months on record. So from the volume perspective, you know, we have had these wacky trends day to day and week to week. But the month of March we filled 9,000 prescriptions and that would be our biggest month since we opened.

Speaker 5:

Another comment to make as I go forward, the specialty pharmacy we operate has morphed into a hybrid pharmacy. So we're mixing in retail volume as well as specialty, but the density of the service and the depth of the program, really tenets on specialty pharmacy. And we have, right now, I think we have 13 embedded specialty liaisons and I'll talk about that more as I go forward. So in early to mid-March, we saw our first activity requiring us to respond. We peaked. So the number of BayState Health bedded COVID-positive patients peaked in April on April 9th. We picked that up 179. We now have a dropoff to the mid sixties. So we've seen a dramatic, you know, up slope and then max and we're starting to PLR. I'm sure it's nowhere near the magnitude of what Frank has seen at Montefiore, but nonetheless it's causative, you know, dramatic amount of work and reaction in science and workflow modification, etc.

Speaker 5:

We out of the gate, we immediately focused on our employees as well as our patients and caregivers. You know, the safety of individuals without you know, without hurting their care model. We've dealt with dramatic drug shortages. I'll talk about that further. And then we'll talk about some pharmacy operations improvements from a quality and process improvement perspective. So on this slide, I mean, it's barely at this point, it's a standard and it's kind of rhetorical, but you know, we were obligated to protect our employees and our patients quickly. The Plexi glass, these guards were installed in really record time. My son works for a national chain store, but locally and we had our signage and our preventive devices installed several weeks before their store.

Speaker 5:

So we're proud of that. You know, your typical floor demarcations and stop signs. We didn't reconfigure waiting room seating. I mean, in many cases you just don't want people sitting in a waiting room period. We do have the good fortune of a large open lobby. So if we needed to keep one or two chairs and are already small waiting when we would do that. But, you know, patients who are encouraged to not congregate obviously in the small pharmacy space. Very publicly, we strengthened our cleaning and disinfecting processes all entryways to the clinics, the pharmacy you know, pharmacy located in clinics 100% of the entryways were basically blacked and forcing you to a channel through a small opening and have that interaction with the nurse. And surgical masks were handed out.

Speaker 5:

We did go to an old visitor policy you know, at one point and with our retail pharmacy located there that posed dozens of challenges about people coming in to get refilled. As was mentioned earlier. I mean, we are in sync with the you know, we've deployed clinical pharmacists over time to be involved in direct patient care, all of that. And he's really modified to be telephonic basically following in lock step with the physicians. So the clinical pharmacy team had their schedule of appointments and just converted them to telephonic interactions. We've redesigned the logistics around prescriptions. As the specialty model is really predicated on a currier, but some people do walk in. Also we've pushed out a curbside delivery model as well as lobby based. So if the main hospital you know, we would deliver prescriptions to the lobby on demand and of course, home delivery in and of itself.

Speaker 5:

That's our anchor really for specialty. But we were obligated to grow that simultaneously on the on the concurrent retail side very relevant to this audience. We moved quickly to send our embedded liaisons to a remote model. We did keep some for clinical and disease reasons. We did keep our two oncology liaisons on site as we did keep our reproductive medicine liaison on onsite from a drug supply perspective. I mean, it's kind of funny how early in the early going there was just this dramatic push for the anti-malarials. The chloric went in the high Vassie Flora when the four patients that were chronically ill with RA or Lupus were coming in and they wanted extended supplies not knowing when they would want to leave their home again. So ironically, we're we're running out of the drugs for the wrong reasons.

Speaker 5:

That has settled down substantially outside of our president novel, putting himself on hydraulic flora when in the subsequent demand. But the push for 90-day supplies, the insurers have relaxed their rules and early refill overrides are now commonplace. And as I mentioned a minute ago, we have this challenge. We own our own courier. So, we have this challenge of now, your specialty patients competing with this dramatically growing the retail population. And we prided ourselves on same day capabilities and in some cases, we've had some conflicts with sustaining that Albuterol, as you all know the NBIS early on out of the gate, tremendous demand and supply challenges for us. At one point we were looking into Primatene Mist, which is basically a epinephrin product, which was reformulated in December of last year.

Speaker 5:

I mentioned the couriers where we're dealing with this issue today. We dealt with it last week and it will continue to be a challenge for us going forward as this whole thing changes our pharmacy residents, as I mentioned has shifted the health reminder telephone campaigns are our BayState Specialty Pharmacy adherence calls have been upgraded to what we would call a wellbeing or an outreach call. This has been a tremendous for lack of a better word, call it a marketing tool for us. And the RX capture results are also quite dramatic, you know, on the last slide, just to restate some of what was mentioned earlier to bring it to life. Yes. In April and May, we're very dialed into this tele-health movement. We've got our own challenges around preserving our 340B value due to the encounter files, the way they're recorded and transmitted.

Speaker 5:

What do we face day to day? We desperately want to get our liaisons back on site to support prior auth financial assistance and general care. But we are challenged with the logistics around where they were, where they sit when they arrived back on site, etc. We did get a temporary pharmacy license for an adjoining state, the state of Rhode Island. We did have some patients there. That was a strategy that we employed. One of our pharmacies has basically adopted a COVID kit strategy. When patients were in the building we were giving them miniature OTC kit if you will, so that they wouldn't have to make a stop on the way home. We did have one particular case which is now being examined more systemically of people who ran out of food and the pharmacy department was involved in helping them stay home on the post-traumatic side.

Speaker 5:

This is a, you know, this is scary stuff. I think Steven mentioned it. We're all working diligently on today or we're also mindful of what the summer is going to bring. You know, then you need more couriers that they need more vehicles. What are we going to do with strip mines and stamping? Are people going to stop taking meds cause they can't afford them? You know, we're diligently tracking expenses because of the federal monies that are available. And, unfortunately, we don't know what the new norm will be. We talk about it. But what we're seeing today, we don't really know what this will look like in three months, six months or a year or so. I think that wraps up my portion. Thank you all for your attention.

Speaker 1:

Okay. Thank you so much Gary for that presentation and obviously I think unfortunately we're sharing and seeing the same message across both our partners and other his health systems across the country. As a reminder, we are a hundred percent available for any questions that you may have and I'm sure is welcoming questions as well. We'll make sure that his contact information is made available to you and as I mentioned earlier, the slides and the recording will be made available. Additionally, I had mentioned our policy briefing that we send out on a weekly basis. We also send out a COVID update on a weekly basis to our partners who certainly would welcome the opportunity to share it with others. It's a very tactical document that helps with things from payer overrides to just current updates and pharmacotherapy. So if you have an interest in receiving that, please do reach out. Again, thank you so much for your time. Thank you, Gary. And then any questions, just please feel free to reach out to any of us. Thank you again and have a great Friday.