The Continuation of Care

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This year marks my 25th anniversary as a faculty member at Thomas Jefferson University, something of which I am extremely proud. It is also the 25th anniversary of my service on our Pharmacy and Therapeutics committee, where I have the privilege of chairing the Medication Quality subcommittee. This editorial is focused on the work of the Pharmacoeconomics and Cost Clinical Effectiveness (PEACE) committee, an important group that I have written about previously.1

A recent project by the PEACE committee that was carried out by very capable members of the Department of Pharmacy at Thomas Jefferson University Hospital (TJUH) deserves further dissemination. Let me explain.

When a patient is admitted to TJUH, which occurs 36,000 times annually, the average stay in our hospital is approximately 5 days. On discharge, the vast majority of patients receive multiple prescriptions for the continuation of their care. Here is where the challenge begins. As most of our readers know, third-party payers, managed care companies, and other healthcare groups have programs in place that provide cost-effective pharmacotherapy for their patients. This is often characterized by several key strategies. Let’s first describe these strategies and then connect them back to the discharge process.

Managed care programs are designed to rationalize the pharmacotherapy process. This starts with the design and implementation of a formulary—the list of drugs that are paid for by the entity in question. Formularies can be open, closed, or tiered. In an open formulary, nonformulary drugs are available, but usually at a very high out-of-pocket cost to the patient. Generally speaking, a closed formulary means that the payer will not reimburse the pharmacy for nonformulary drugs. In a tiered formulary, patients pay progressively greater copays for the preferred and the nonpreferred brand-name drugs.

Yet another strategy is step therapy, which is the practice of beginning drug therapy for a medical condition using the most cost-effective and safest drug, and then stepping up through a series of sequences of alternating drug therapies if the preceding treatment option fails. Typically, as a patient progresses through the therapeutic steps, the drugs become more expensive. Another strategy may be quantity limits, in which the payer will only pay for a specific quantity or supply of a medication.

So, here comes the challenge. On discharge, when physicians provide patients with prescriptions for the drugs they were receiving in the hospital, they typically do so not knowing which restriction strategy may apply to these prescriptions. Simply put, a physician prescribes a drug that he or she deems critical to the patient’s ongoing recovery, without knowing whether (or to what extent) the drug will be covered by the patient’s insurance.

This challenge is of critical importance to patients and to physicians. If the drugs are not covered, if they are very expensive, or if they are potentially not even available, we are then setting patients up for a series of potentially dramatic challenges and possible negative health outcomes. Regrettably, many physicians, nurses, and even pharmacists often do not ask patients, while they are still in the inpatient setting, which drugs will be covered by their particular insurance plan upon discharge.

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We therefore have to ask the question, “Can our recently discharged patients continue using the medication that was prescribed while they were in the hospital?” One process improvement that may help is for providers to routinely say to patients on their admission to the hospital, “Tell us more about your drugs, and how they are paid for in the outpatient setting.” If the medical team decides that the patient needs a specific prescription while still in the hospital, then the team can also potentially confirm that this drug will be available if needed on discharge. If the provider team discovers that a particular drug is not covered as an outpatient, they can work to provide a suitable substitution before the patient’s discharge from the hospital.

Although this means extra work for the harried inpatient provider team, it may avoid problems for the pa-
tient (and a potentially unnecessary readmission) down the road.

The PEACE committee examined a handful of clinical examples. I will summarize aspects of their analysis here, after providing a brief context. Local payers in TJUH’s market include Independence Blue Cross and Aetna, which have 3-tiered open formularies. The managed Medicaid payers, all of which have closed formularies, are Keystone First, HealthPartners, and United-Healthcare Community Plan. Perhaps ironically, Jefferson's self-funded insurance plan, which is implemented through OptumRx, has a 2-tier open formulary.

Burdening our patients with prescriptions that require prior authorization (which may take days after discharge to be approved) or, even worse, giving them a prescription for a drug that is not even on their insurance company's formulary, is an all too common problem. I am confident that we can do better for our patients.

Now that we know the players, let's review the example of fluticasone plus salmeterol (Advair). Independence Blue Cross and Aetna have a prior authorization program implemented for patients who are prescribed fluticasone plus salmeterol; Keystone First and HealthPartners do not even have fluticasone plus salmeterol on their formulary. For Jefferson employees who happen to be admitted to our own hospital, there are no restrictions on fluticasone plus salmeterol.

A second example is celecoxib (Celebrex). Again, Independence Blue Cross and Aetna have a prior authorization program, whereas Keystone First has a step therapy program. Do most providers in our busy university hospital have any knowledge of these restrictions or regulations regarding a specific medication? I very much doubt it.

Let's consider a potential solution to this very important issue regarding the availability of medications after discharge. I would offer the following multipoint plan:

1. All providers must ask patients about the insurance coverage for their current medications and any drugs that they may plan to take in the near term. This will require teamwork on the part of the physicians, pharmacists, and others to get the answers to these sometimes very complex questions.

2. It is incumbent on the care team to facilitate prior authorization while patients are still in the hospital, so that we do not unnecessarily prolong their hospital stay and incur an even larger medical bill.

3. There must be greater communication between the inpatient and outpatient teams, such as the admitting physician, hospitalists, and other people caring for patients exclusively in the ambulatory setting. This is particularly critical for patients receiving inpatient and outpatient chemotherapy for cancer.

If your institution has a robust program already in place that facilitates the transition of care from the inpatient to the outpatient settings, especially with regard to prescriptions for critical medications, I sure would like to learn more about the progress you are making.

Burdening our patients with prescriptions that require prior authorization (which may take days after discharge to be approved) or, even worse, giving them a prescription for a drug that is not even on their insurance company’s formulary, is an all too common problem. I am confident that we can do better for our patients, with a commitment to improving the continuation of care.

As always, I am interested in your views, and you can reach me via e-mail at david.nash@jefferson.edu.

Reference