Announcer:
Welcome to 340B Insight from 340B Health.

David Glendinning (00:15):
Hello from our booth in the Virtual Exhibit Hall at the 340B Coalition Summer Conference. Welcome back to 340B Insight, the podcast about the 340B Drug Pricing Program. I'm David Glendinning with 340B Health. This episode is sponsored by Macro Helix who is a leader in 340B, whether implementing a new program, establishing a contract pharmacy, or simply optimizing your existing 340B procedures, you need a collaborative partner who understands your needs and uncomplicates the complicated. You need Macro Helix because together we got this.

Our guest today is Sarah Dodson, the 340B Program Director at Ascension Via Christi in Kansas. She has a great story to tell about how her system uses a 340B supported clinic to bring care to people where they live by sending nurse practitioners to the homes of patients in need. But before we go to that interview, let's take a minute for a roundup of 340B news. It's been a very busy time.

The drug manufacturer Eli Lilly has taken an unprecedented step by announcing that it has stopped offering 340B pricing for the drug Cialis when a covered entity is purchasing that drug to be dispensed through a contract pharmacy. Although the move at this point involves a single medication from one drug company, it is widely viewed as a test case for how the 340B statute might be applied to contract pharmacies. If Lilly is able to restrict hospitals with contract pharmacy arrangements from accessing discounted pricing on eligible drugs for those pharmacies, it could expand that policy to other medications and other manufacturers might be encouraged to do the same. You can find out more about what the Lilly development means for covered entities in the show notes for this episode.

Meanwhile, lawmakers on Capitol Hill continue to stand up in bipartisan support of the 340B Program. In one of the latest demonstrations of this support, a group of three Republicans and three Democrats in the US Senate sponsored a new pro-340B bill authored by South Dakota Senator John Thune. It would ensure that 340B hospitals would not lose access to discounted drug prices because of financial and operational changes they have had to make to respond to the COVID-19 public health emergency. The senators are pushing congressional leaders to include the measure in their next COVID assistance package. Again, you can find more information in the show notes for this episode.

David Glendinnning (02:58):
Today's feature interview is with Sarah Dodson. Dr. Dodson earned her Doctor of Pharmacy from the University of Missouri, Kansas City. She's been working at Ascension Via Christi for five years. Before that her experience included working as a community pharmacist with a focus on chronic disease state management at an independently owned pharmacy, which also was a 340B contract pharmacy for a local hospital. Our own Myles Goldman first sat down in person with Sarah at the 340B Coalition’s Winter Conference in San Diego back before the current pandemic prompted everyone in the 340B world to find new ways to stay connected with each other.

Here's what she had to say.

340B Insight Dodson Final Transcript
Hello, I'm Myles Goldman, Communications Manager at 340B Health. Today our guest is Sarah Dodson, the 340B Program Director at Ascension Via Christi in Kansas. Sarah, welcome to the podcast and thank you for taking the time to speak with us.

Sarah Dodson: Thank you for having me.

Myles Goldman: So I just want to start off by learning more about you and your role at Ascension Via Christi.

Sarah Dodson: Sure. So I'm a pharmacist by training, as you mentioned, and I've been with Ascension Via Christi for about five years, and all of those years I have been the 340B Program Coordinator and now Director for our 340B Programs. The reason why I got into pharmacy in the first place was I grew up in a lot of rural communities and saw a need and the benefit that our local pharmacist had on those communities. So a lot of my early focus was on things like diabetes education for patients, thinking of cardiology services like hyperlipidemia, high blood pressure, those types of things, and really focusing on helping patients manage those disease states at home.

And then one of the common themes that you tend to see come up is access to medications and medication affordability. So when I had a little bit of 340B experience working at that contract pharmacy, and so this position came up at Ascension Via Christi. And for me, I was really drawn to it because of the opportunity to have an impact on patients, whether it be by directly affecting the price that they're paying for a prescription but also through seeing how 340B can increase access to care and services and those types of things.

Myles Goldman: And that's all great to hear. Tell me more about Ascension Via Christi itself and the community in Kansas that you're serving.

Sarah Dodson: Sure. First of all, Ascension Via Christi is the largest provider of healthcare services in Kansas. So we have a number of hospitals, clinics and other facilities throughout the State of Kansas. We have two 340B covered entities. We have one rural referral center in Southeast Kansas and Pittsburgh, Kansas. And then we have a DSH 340B entity which is located in Wichita, Kansas. And then we have a number of child sites associated with each of those and that provide services at other locations throughout both of those areas.

Myles Goldman: And one big reason we really wanted to talk to you is Ascension Via Christi has created a model called the Community Cares Clinic. So we'll just start with the basics. What is it and what does it do?

Sarah Dodson: The Community Cares Clinic is a clinic that is located on site within the hospital where we see our patients. It's open to all patients regardless of their insurance status. The clinic provides a variety of services including primary care, behavioral health, and specialty care. Our goal is to help patients manage chronic conditions, prevent illness, and improve overall health outcomes. 

Myles Goldman: And that's all great. So I want to talk more about the Community Cares Clinic. What are some of the challenges you've faced in implementing this program?

Sarah Dodson: One of the biggest challenges we've faced is ensuring adequate funding for the clinic. As we've expanded to additional locations, acquiring the necessary resources to support these programs has been a significant challenge. Additionally, ensuring that our patients understand the value of these services and how they can benefit them is another challenge we've encountered.

Myles Goldman: And how have you overcome these challenges?

Sarah Dodson: We have worked closely with our healthcare providers and administrators to develop a sustainable funding model. By leveraging partnerships and grants, we were able to secure funding to support these additional locations. Additionally, we have focused on patient education and outreach efforts to increase awareness and utilization of these services.

Myles Goldman: That's really great. Finally, what are your future plans for the Community Cares Clinic?

Sarah Dodson: We are constantly looking for ways to improve the services we offer and expand our reach. Our future plans include developing telehealth options to provide care to patients who may not have access to clinics in their community. Additionally, we are exploring opportunities to integrate more mental health services into our clinic to better address the needs of our patients.
The Community Cares Clinic is one of five services that we offer, which is really provided in collaboration with four other services, which is our transitional care clinic, the COPD clinic, a heart failure clinic, and then we have a service that is an ED navigator service. And so all five of these are really intended to work together to address a lot of the barriers and challenges that our patients face. The Community Cares Clinics specifically is a nurse practitioner house call model. So when we think about barriers that patients face in accessing care, one of those can be mobility or transportation-related issues.

This clinic actually focuses on patients who have COPD or heart failure, who have a taxing effort to get out of their home. So with both of those disease states, patients may have mobility issues, they may not be able to come in to a traditional doctor's office or clinic as often as they need to to receive the care that they need. So I think what common sense would tell us is, "Well, the patient needs care and they can't come to us. Why can't we go to them?"

Myles Goldman (07:08):
And how does this work? What type of patients do you see? Do they call you up, et cetera?

Sarah Dodson (07:12):
Yeah. So that's a good question. So patients are identified for this service through a number of ways. So some of the other clinics that I mentioned of those five services that we offer, one is called the transitional care clinic. And so one thing I should have mentioned I guess earlier on, is that all five of these services work really collaboratively together. A lot of people who work with the Community Cares Clinic are on the same team for those other services that I mentioned.

So it may be a physician who's identified a patient who might benefit who refers them to this clinic. They may be a patient of our COPD clinic already and it's recognized that they're having a hard time getting in for their visits. So, there's really no set way that a patient is identified. It's just I think an understanding from all the providers involved of what the service is, who can benefit and then being able to, when you see a patient who's struggling, to be able to connect them to this service and hopefully benefit them that way.

Myles Goldman (08:07):
And once they are connected to the service, is there a frequency that the visiting nurse comes into their home?

Sarah Dodson (08:13):
It depends on the patient need. And while it is a nurse practitioner-led team, there are a number of other services or providers that can be included as part of that service. So the patient may also see home health pharmacy maybe involved in their care. Family, of course, we consider part of that team if they're helping provide care for the patient, and while they aren't going directly to the home, we also consider, of course, the patient's other providers part of that care team. So there's... Well, the nurse practitioner is probably the one going to visit the home along with some of those other team members. There's really frequent communication to their primary care provider, any specialist that they see such as cardiology, pulmonology, as well. So even if those people aren't able to go into the patient's home,
they're, again, directly involved in care. But with the frequency just set based on what the patient needs at the time.

Myles Goldman (09:03):
Are there even times where a patient has the opportunity to reach out on their own if it's in between visits?

Sarah Dodson (09:09):
This is a service that's offered 24/7. The patient can reach out at any time, and that's, I think, some of the biggest feedback that we have from patients is that they don't feel alone. If they're at home, maybe they've just been discharged from the hospital, they're overwhelmed with information, they can reach out at any time and have access to someone who is able to assist them, whether or not that means the provider is able to go to the home immediately or not. It's a service that's offered to that patient at any time.

Myles Goldman (09:36):
And when a patient, if they reach out at, let's just say they're reaching out at 2:00 in the morning, are they speaking to someone who's in Kansas at Ascension?

Sarah Dodson (09:46):
Yes. Yes, definitely. It's a very close-knit team that's providing that care to patients.

Myles Goldman (09:51):
That's great. And I meant to ask earlier, since you're in a rural community, how much is transportation a factor and a barrier to being able to come to the hospital?

Sarah Dodson (10:00):
Yeah. Actually for this service that's provided, it's provided in the Wichita area, so it's a little less rural, not that that might not be a factor for some of our patients. I would say it's probably an even mix having access to a vehicle. If the patient doesn't have a car, maybe they're having to rely on a family member or someone like that to take them, but I think as much as it's that, it's probably more... When you think about COPD and heart failure and the patient being physically able to come in, to get up, get around and make that trip to the clinic and feeling up for that as opposed to being able to relax at home and have someone come to you. I think that that's probably the bigger benefit we see for this patient population.

Myles Goldman (10:41):
And how long has the Community Cares model been in place for?

Sarah Dodson (10:45):
The services in general were begun around 2015 and then added over time gradually.

Myles Goldman (10:52):
And let's talk about how 340B plays into all of this. What is the role of 340B in the Community Cares Clinic?
Sarah Dodson (11:00):  
Sure. So the primary role of 340B is that the Community Cares Clinic as well as the other four services that work in conjunction with the Community Cares Clinic are funded by our 340B savings. And these are services that 340B really allows us to support and to offer in ways that without 340B we might not be able to, thinking about things, especially that are non-traditional, and when you’re starting something like this upfront, maybe not having a really big grasp on what the impact is going to be but still being able to be innovative and to try and address those again through non-traditional ways.

We had a patient who had been hospitalized a couple of times for COPD and during the course of her hospitalizations there wasn't anything on the surface that was identified as especially concerning, but it's not uncommon for patients with COPD to be in and out of the hospital frequently. But because she had been hospitalized a couple of times, she was identified by the provider as someone who might benefit from the Community Cares Clinic.

So when the nurse practitioner went out to visit the patient, they actually found that she was living in a trailer that was towards the back of a salvage yard that had no electricity, had no plumbing, and just generally speaking the environment that she was in was not the ideal environment for her to be able to implement the plan that her providers had sent her home with from the hospital, and posed all kinds of challenges. But with something that, when you're speaking with the patient there, she didn't see it, I suppose, as unusual. There was nothing that was really a red flag about what's going on at home that we could be doing.

So I think that's something that when you're looking at things from either the clinic setting or the hospital setting and trying to help people, it really isn't always visible until you actually go in and see where they live and what their day-to-day life is like. And of course from that encounter, then the nurse practitioner and the social work team were able to get her connected to other resources and really address some of the bigger challenges that she was facing which probably weren't as easily recognized in the hospital.

When we're looking at the care that we provide in the traditional clinical setting, whether it's the hospital or the clinic, but that care only accounts for about 20% of a person's overall health, and the other 80% is actually influenced by so many other factors outside of that clinic setting. So, again, I think that's one of the big reasons why the service is so valuable. That's one of the reasons why there's a need for services like this, is because of course you can do a lot for patients in the clinic or the hospital and we aim to provide the best possible care that we can there. But sometimes that's not enough for every patient. And there's a real opportunity, I think, to address some of those other factors outside of the traditional setting.

Myles Goldman (13:48):  
That's really an incredible stat there and really gets... This is truly a holistic care model in a lot of respects, right?
Sarah Dodson (13:56):
Yes, definitely. When we talk about the goals of the Community Cares Clinic, the first and foremost is to meet patients where they are, increase their ability to access care. And then another one is for patients to learn to manage their disease in their own home. So if you're able to work with the patient in their home and see, "Okay, what barriers are there? What can we address with you? Maybe we need to adjust the plan that we had set because it's just not going to work for you when you get home." And sometimes it takes actually being with the patient there to recognize what all of those challenges might be.

Another goal is to, of course, have better quality of life for patients. And then one way of doing that is to decrease their risk of future ER and hospital visits, and thinking about, we hope for our patients to receive from this service. One thing that isn't a goal for every single patient, but that can really mean a lot to some patients is, if there is a need for someone to transition to hospice or end-of-life care, that can be really challenging. You could probably have a whole separate discussion on what that transition is like. But one of the goals of this team is, when it's time for that transition to happen, that this team can really facilitate that process and make it as smooth as possible for the patient, their family and their caregivers as well.

Myles Goldman (15:10):
I know that the program is fairly new, but what are some of the early patient outcomes that you're seeing?

Sarah Dodson (15:17):
Yeah. The Community Cares Clinic in combination with the transitional care clinic, which is another service that's offered in conjunction with this service, in the first year that these two services were offered together, they served over 500 patients and they reduced avoidable hospital admissions by 93%. So I think we know most providers can recognize the value of something like this for patients, but to be able to demonstrate that and to see, "Okay, this isn't something that's just feel-good on the surface, but it actually does have an impact on people and their lives."

Myles Goldman (15:54):
As more and more of these conversations around outpatient care and going to where patients are occur, what is other advice you would give to hospitals who want to start a program like Community Cares?

Sarah Dodson (16:08):
I think first and foremost would be to look at your community and figure out for the patients that you serve, what are their barriers? For us, transportation and mobility are a common problem for patients, and I think most communities are going to have that challenge. And that, I think, trying to figure out what those barriers are and then taking a step back from, "Okay, how do we usually provide care? What's the standard?" But look at, "Okay, we have this problem. Our patient has this problem. How can we help them?" Thinking outside the box with it.

And I think, looking at things like this, that's obviously what we're thinking about, "We have this specific problem. What can we do to address it?" And I think, again, 340B is one way that you can look to support services like this, that upfront you may not know exactly what the outcomes are going to be or
what the exact benefit is going to be. But it's an opportunity to, again... We have 340B program for a reason to stretch our resources and this is one really good way to use 340B to figure out how to reach vulnerable patients.

Myles Goldman (17:17):
Were there challenges in connecting 340B to the Community Cares Clinic?

Sarah Dodson (17:23):
Yeah. I personally, when I think about 340B and I hear a lot of talk about audits and what auditors are looking for and thinking about things like diversion and the patient definition, one thing that you often hear is, if you're thinking about whether 340B drugs are administered, or whether it's a prescription that's originating from a service, can you count those as 340B eligible? And a lot of the guidance at least the audit findings are centered around, was the patient seen in a location that was registered on the 340B OPAIS data base? Well, if you're seeing patients in their home, of course, those aren't going to be addresses that are all registered. And so this is one area that we have reached out to Apexus for because it can be a gray area, especially when you're trying new and innovative things.

Sometimes the guidance isn't always up to speed with what you're trying to do. I would say that for anyone looking to offer a service that may be a little bit nontraditional, that would be the first place that I would go and just make sure that, of course, the FAQs that are available online, but also utilizing the help desk or technical assistance call, whatever the case may be to make sure that what you're doing is both supporting our patients, but also in a way that we're still going to be adhering to everything we need to for 340B.

Myles Goldman (18:43):
It's good to cover what those technical challenges are. Sarah, I want to thank you so much for your time today. It's been great to learn more about the Community Cares Clinic, and we're looking forward to seeing all the great work it continues to do in the future.

Sarah Dodson (18:57):
Thank you.

David Glendinning (18:58):
Our thanks again to Sarah Dodson for telling us all about Ascension Via Christi's Community Cares Clinic. We appreciated learning more about this innovative approach to expanding 340B's reach well beyond the walls of the hospital. We look forward to spending the coming days here at the 340B Coalition Summer Conference learning about many of the additional ways covered entities are using their 340B savings to reach more patients living with low incomes and living in rural areas.

Please stop by the virtual exhibit hall during conference and visit the 340B Insight booth. There you can hear other episodes and answer trivia questions for a chance to win a prize. Do you have a question about 340B or a program issue you would like us to cover on a future episode of the podcast? We are always happy to field these questions and ideas. You can email us at podcast@340bhealth.org. We'll be
back with a new episode in early August, recapping some of the conversations that took place here at the conference. Until then, thanks for listening and be well.

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