Speaker 1 (00:04):
Welcome to 340B Insight from 340B Health.

David Glendinning (00:14):
Hello from Washington DC, and welcome back to 340B Insight, the podcast about the 340B Drug Pricing Program. I'm David Glendinning with 340B Health. The nation's response to the novel Coronavirus 2019 pandemic has focused our attention on the frontline healthcare providers who are spearheading that response. Our guest today is a leader with a 340B hospital system that was one of the first to deal with a COVID-19 outbreak. That experience can illuminate what many other safety-net hospitals and health systems throughout the country have had to do to prepare. But before we go to that interview, let's take a minute to talk about the latest news on 340B.

David Glendinning (01:02):
Senator Ben Sasse, a Republican from Nebraska recently introduced legislation aimed at aiding rural hospitals during the public health emergency. 340B figures prominently in that legislation. It would protect disproportionate share hospitals from losing 340B eligibility because of pandemic related shifts in their payer mix. In addition, hospitals that normally are prohibited from using a group purchasing organization to buy 340B drugs would be permitted to do so to avoid shortages of needed medications. 340B advocates are urging lawmakers to consider the Sasse language as they work on the next version of COVID-19 legislation.

David Glendinning (01:42):
Meanwhile, the Centers for Medicare & Medicaid Services has concluded its controversial survey of 340B hospitals’ drug acquisition costs. The agency has indicated it intends to set future Medicare payment rates to many 340B hospitals at or close to those acquisition costs. That would perpetuate the deep payment cuts to those hospitals into 2021. The first inkling of that policy likely will come in July. You can find additional resources on these developments in the show notes for this episode.

David Glendinning (02:22):
Today's feature interview is with Mike Bonck. Mike is Manager of Pharmaceutical Services at CHI Franciscan Health in Tacoma, Washington, which is part of CommonSpirit Health. He's been with that health system for more than three decades and has a wide variety of responsibilities there, including supporting the 340B programs at Chi Franciscan's four DSH hospitals, its Rural Referral Center, and its Critical Access Hospital. He also is finishing his term as a member of the board of directors here at 340B Health.

David Glendinning (02:53):
The Seattle-Tacoma area was one of the first parts of the country to deal with cases of COVID-19. Mike's system faced a variety of challenges, including mobilizing to open COVID-19 specific units and ensuring that those facilities had appropriate levels of staffing, ventilators, and other crucial medical supplies. Our own Myles Goldman spoke with Mike about how CHI Franciscan rose to the challenge. Here’s what he had to say.

Myles Goldman (03:19):
Hi, I'm Myles Goldman from 340B Health. I'm joined by Mike Bonck. Mike, thank you for making time to speak with us. Welcome to 340B Insight.

Mike Bonck (03:29):
Thank you Myles for the opportunity to join.

Myles Goldman (03:32):
We're going to be talking today about the COVID-19 pandemic and how it's been impacting your hospitals. The Seattle-Tacoma area was one of the first in the United States to experience an outbreak of COVID-19 cases. Can you tell us what your system experienced?

Mike Bonck (03:52):
The first Washington State cases began with the patient up in Everett at Providence in Everett. He was the first actually patient in the US, and then it started expanding. And especially as the issue with the nursing home up North of Seattle, we even received some of those patients in the long run because of the Seattle area and North of Seattle being overwhelmed with cases. We first experienced a significant surge in early March to April, and it was a very busy time because we didn't know quite what to expect. And we immediately set up individual hospital and system command centers. We basically met as often as two to three times a day, seven days a week, looking at everything related to emergency preparedness across the organization, how each hospital could support one another, changes that we need to make related to PPE supplies, medication supplies.

It was a very intense time. And also in terms of trying to potentially get involved in studies that were ongoing since so little was known at that time and still is known about adequate treatment of COVID-19. At first we were very short with PPE supplies, although that resolved over time. But a lot of decisions had to be made early on in terms of conservation of PPE to ensure both our employees, our physicians, our staff members had adequate protection in treating patients and that patients were safe also.

In the State of Washington originally, it was only the state lab that was doing testing and that's about 60 miles away from where we're at. And so the turnaround was very lengthy. It took up to four days or more to get test results. Then University of Washington in their Virology Lab, started doing testing. So that helped to take some of the relief off. And now of course, there are more rapid testings that we're able to do locally within our hospital labs that have really helped that process and turned some of those patients around quicker.

Myles Goldman (06:05):
And what was it like personally for you during those first few weeks? I imagine a lot of long days.

Mike Bonck (06:11):
Oh yeah, I tend to work long days anyway, but it made them a little bit longer. And I think even with the weekend calls and just a lot of issues. There were a number of different drugs that we discussed and had to make decisions internally with our physician groups within the region and pharmacy groups and other leaders on what medications we were going to support for use and follow up for patients. We ended up becoming involved in two of the remdesivir trials through Gilead. We're still involved, although they may
be coming to an ending soon. So it was very busy in terms of that, because things were basically changing, not really on a minute to minute, but certainly on a day-to-day basis, week to week basis, especially early on with some of the information that was getting published out of China and some out of Europe, because they were a little bit ahead of the U.S. in terms of number of cases and some of the medications that had been used for patients.

Myles Goldman (07:13):
The healthcare professionals caring for patients with COVID-19 are of course, true heroes to all of us. And it must be taking a tremendous toll on all the men and women at your hospitals this pandemic. Can you share with us how your colleagues are coping?

Mike Bonck (07:30):
Well, there's a lot of support from a lot of our teams and especially our pastoral care team in terms of support for employees and trying to take some downtime and that sort of thing. Certainly, it's very challenging with the dangers associated with treatment and with direct care and ICU, ED COVID units. Wearing appropriate PPE is very essential. We're blessed that no one within our pharmacy group has actually turned positive with over 300 FTEs regionally within all of our facilities.

But certainly there's a lot of family concerns. We've seen many employees in different disciplines, as we've seen across the country, will tend to social isolate themselves even when they come home. Some might live in the garage during the time, especially if they've become positive or have symptoms. So there is a lot of stress on families. And of course, in many cases, it's been very difficult because of visiting rules where a patient near death may only be able to talk to someone over the phone as opposed to in-person, or there may be only able to be one person there at time of death. So that's, I think been very challenging both to our staff and to patients and their family members for sure.

Myles Goldman (08:55):
With all that has happened, is there a patient story that stands out to you that demonstrates the successes and the challenges that your health system has faced?

Mike Bonck (09:06):
Well, I think one interesting one. We had an employee actually, who came down with COVID-19 and she and her husband both did. They were both hospitalized. He had a milder case and was discharged within a few days. She had a more severe case, had not actually progressed to be on a ventilator, but was actually one of our first patients enrolled in the remdesivir trial, and after about 14 days, was able to be discharged from the hospital and both of them are recovering at home. So it was a very nice success story.

Myles Goldman (09:43):
We've seen examples of hospitals playing celebratory songs as they discharge. Has CHI Franciscan come up with a celebratory song?

Mike Bonck (09:53):
We do Here Comes the Sun. So it is nice. We actually do something in a birth of a baby every time, but actually decided to do Here Comes the Sun as a positive emblematic song for that person's recovery and being able to leave the hospital and go home.

Myles Goldman (10:13):
That's definitely a great song. Can you talk a little bit more about shortages in terms of drugs and/or in terms of equipment?

Mike Bonck (10:23):
Early on in terms of medications, there were some fears that even inhaler products that are used for bronchodilation were going to be short. So unfortunately, sometime that leads to trying to purchase extra supply, that could cause a shortage in and of itself. But we did do a bit of that, not to create a shortage, but to provide enough inhalers for support. There've been shortage of neuromuscular blockers that are often used on ventilated patients if they have severe cases and need a muscle blockade. One of those drugs is cisatracurium was especially in short supply. We don't tend to use a lot of it, but we were able to obtain some when we needed, but it was again, touch and go a number of times.

And then there's just been a whole plethora of other drugs that have been in short supply. Somewhat due to COVID-19, it's been a longstanding problem in the United States with drug shortages, probably for the last three to five years plus. COVID-19 just exacerbated that problem. We're very lucky because we have a system of hospitals locally, so we can share in between our hospitals and even potentially, across the United States if needed, with our larger system.

Myles Goldman (11:46):
Are there best practices that you found to help at least somewhat address these drug shortages?

Mike Bonck (11:54):
Well, it's all about working closely with your medical staff and having contingencies in place, whether through our formal P&T committees or through leadership where we'll get together quickly and make a determination of what shortage we may be facing and determine alternatives that we're going to use. And that's really, I think all systems tend to try to do that, but we think we're pretty good at it. And we have even a list of drugs that we deem necessary for COVID-19. We do an inventory once a week and share that across the region, both with practitioners, nursing staff, and pharmacy staff. And then if anything else comes up in between, we go straight to those leaders to let them know what we're going to have to do in order to facilitate care if we have an acute shortage of a product.

And most often, there are alternatives that can be used. One might be a little bit easier to use than another, but we will share that and then get that information spread out as quickly as possible, make changes in our electronic health record if need be and move on with those changes.

Myles Goldman (13:07):
Are there other lessons that you can share with hospitals who might be on a different place on the curve?
Mike Bonck (13:13):
Well, I think it's all about planning. Making sure that everyone is in sync together in terms of medication supplies, what you're going to use from a pharmacy perspective, making sure that you have appropriate amount of PPE and other just in general supplies that are needed for treatment and making sure that your staffs are ready and you have good communication lines throughout your organization. It's all about communication.

Myles Goldman (13:42):
Many hospitals are having to deal with significant financial losses from having to defer elective procedures for a while. Can you share with us how the pandemic is affecting finances for your hospitals?

Mike Bonck (13:53):
I will tell you from my discussions, not only internally, but within our organization as a whole and within other hospitals within the region, everyone is hurting from COVID-19 because when you think about it, you really shut things down in early to mid March, and so we're two months into that. And March was not a good month for any hospitals that I'm aware of. April was the worst and May probably will not be much better because of course, you may start doing elective surgeries again, but you're not going to get paid for those until probably into June. So it's been very, very challenging. There has been stimulus money from the CARES Act that has come out and been distributed to hospitals, but far from meeting their needs with those stimulus funds thus far.

Myles Goldman (14:47):
You oversee the 340B Program as it affects CHI Franciscan hospitals. How has 340B been helpful to you during this period?

Mike Bonck (14:59):
I would say the losses would be much worse without it. It's a blessing to have 340B. It's helped and the savings really have helped us over the years to provide care to extended populations and to the poor and underserved, which we're dedicated to in our communities. But without that during this time, it would have been a lot worse than it is. It would have just intensified our financial losses within the region.

Myles Goldman (15:31):
And have the changes made by the government by HRSA to provide flexibility to 340B providers been helpful?

Mike Bonck (15:40):
Yes, I think having some of those guidelines loosened up or a little more flexible during this challenging time has been very helpful. I know we've done more telemedicine within our facilities. I know many other hospitals are doing that. The majority of our medical groups' visits during this time have turned into telemedicine visits. And without that, it would be very, very difficult to be caring for patients. I think we're going to see telemedicine here to stay in a lot higher fashion than what we've probably had in the past. And hopefully, HRSA and all, CMS, HRSA, et cetera, will not just make some of these changes temporary, but realize the importance of making them long term for the better overall care of our patient populations and potentially, expanding the potential for care with certain populations also.
Myles Goldman (16:39):
When you think about the recovery phase, do you also look at it from a perspective of patients who have chronic diseases that normally see are you concerned about what their health status will be as they return to seeing you?

Mike Bonck (16:55):
I am in some cases, because there may be people who have avoided either even the telemedicine visits or who are waiting. We definitely have large number of people who are unemployed across the U.S. as we know. I think it's over 30 million, and we do in this state, it's about 20% of our population. And it's really going to depend too then on how many of those who are unemployed actually do get back and are employed and have insurance coverage. Is there still going to be fear? I think as states start to loosen up and provide the ability for economy to start up again, I think a lot is unknown yet, whether we're going to see exacerbations of COVID.

Myles Goldman (17:44):
Well, thank you, Mike, for taking the time to speak with us today. We wish you well too, as well as your hospitals and the Seattle-Tacoma region as it continues moving through the recovery process.

Mike Bonck (17:57):
Thank you Myles. It's been a pleasure taking part today. I appreciated the invitation and the ability to share our experience.

David Glendinning (18:05):
Our thanks again to Mike Bonck from CHI Franciscan for his instructive and inspiring story. I don't think I'll ever listen to Here Comes the Sun without thinking of the heroic work Mike described. In our next episode of our podcast, we will be speaking with a 340B hospital in a different part of the country that faced and met its own challenges as COVID-19 spread from metropolitan centers to more rural communities. If you haven't already, please be sure to subscribe to 340B Insight on your favorite podcast player so you can hear that story right when it comes out.

David Glendinning (18:37):
And as you are planning your weeks ahead, please register for the 340B Coalition Virtual Summer Conference. This virtual conference will feature more than 50 live and on-demand sessions, three pre-conference workshops, and multiple networking opportunities. It is the best way for you to keep pace with the latest developments in the 340B world. Sessions will include crucial updates on how COVID-19 is affecting operations and compliance issues. You can learn more about the 340B Coalition Virtual Summer Conference at 340bsummerconference.org.

David Glendinning (19:12):
We hope you enjoyed this episode of 340B Insight. Please send your questions and ideas to podcast@340bhealth.org. Thanks for listening and be well.

Speaker 1 (19:28):
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