Voiceover: Welcome to the VA HSR&D Investigator Insights podcast series. In this episode, HSR&D Research Content Editor, Maria Hecht, speaks with primary care provider, Amy Linsky of the Center for Healthcare Organization & Implementation Research, about her work in the area of Effective Medication Management.

Maria Hecht: Well, Amy, thank you so much for joining us.

Amy Linsky: Thanks, Maria. So, I'm a general internist in the section of General Internal Medicine at VA Boston. I'm also affiliated as an Investigator with The Center for Healthcare Organization & Implementation Research, and I am Assistant Professor at the Boston University School of Medicine.

Maria Hecht: What drew you to the VA and to Health Services Research? We know there are a lot of folks who are MDs; about 95% of folks who are trained as MDs come through the VA system. Is that how you get started? And if so, let us know how you came to Health Services Research and why you stay at the VA.

Amy Linsky: It’s actually easier to answer why I did Health Services Research first, which was while I was at the end of my med school and during my residency, I found that I got much more energized talking about the nonclinical aspects that related to the delivery and outcomes above healthcare. So, that was a much easier decision for me; wanting to study ways to improve healthcare.   
  
With respect to the VA, while I did have some exposure to it in my residency, it wasn’t really until I came to fellowship at Boston Medical Center when I was assigned my clinic at the Bedford VA and started doing my research at the Boston VA.   
  
And then, when I was searching for my clinical, my first faculty position, staying at the VA was quite appealing from both the clinical perspective and a research perspective, especially given that most of my research is focused on medications and the VA has a wealth of data related to that.

Maria Hecht: Your work focuses on assessing excess medication supply. So, there are a bunch of factors that are pretty concerning about this issue, both from a safety issue, from a cost perspective.   
  
But what question was of most concern to you prior to the beginning of this particular study?

Amy Linsky: This study started because I was looking at medication reconciliation, which is where you compare what are patients taking to what you have on the record. I was doing that as a quality improvement project with some medical students and we found that it was pretty common, even within the VA at one center, that we had about 10% of the patients had a dupilumab where they had the same medication showing up twice. And the VA is an integrated healthcare system; you would expect it not to happen.  
  
So, when I, as a clinician, discontinue a medication or tell a patient that they shouldn’t take it anymore, that medicine is actually stopped. They can no longer get it from the pharmacy.  
  
If you go to a community provider where they’re written a prescription and you take it to your local pharmacy like a CVS or a Walgreens and there are refills remaining, even if you go to your clinician six months later and they tell you to stop taking it, you can still go to the pharmacy and refill the medicine.   
  
So, we expected it to be lower in the VA because of the way the healthcare system works with the integrated electronic health record. And so, when we were still seeing it happening, we wanted to get a sense of how widespread was this. Was this because the one center we were looking at was in an urban area and there’s many other centers nearby? We wanted to get a sense of nationally, where people maybe weren’t bouncing between multiple VA centers; were they still getting medication – the exact same medications, in some cases – dispensed to them simultaneously?

Maria Hecht: While you were conducting the work, in the process of it, was there an outcome or a finding that really surprised you?

Amy Linsky: So, yes and no. I was surprised by how widespread it was. That said – so, we ended up finding almost two-thirds of the patients had what we called “an overlap episode.” So, we looked for medications that were dispensed from – have actually filled, basically – from a VA. And then, before the prescription ran out, did they have another prescription for that same medicine dispensed again?  
  
We gave a little bit of wiggle room. We gave ten days for them to get pills a bit early because, you know, we don’t want people to run out of meds. People also will maybe be going on vacation or traveling and might need to fill a little bit early.   
  
But we still found, even giving that little bit of wiggle room of ten days, that almost two-thirds of the patients had overlap of the exact same medicine. So, I think I was surprised by how widespread that was.

Maria Hecht: Yes, that’s a pretty big proportion. Did you look specifically at different types of medications? Or were you focusing on just a widespread variety?

Amy Linsky: We were looking at all-comers. We were not specifically focusing on opioids or other controlled substances, which, in theory, should be less likely to have the overlap because they have to be rewritten as a new prescription and because we were paying so much more attention to those dispensings.  
  
With respect to the medications outside of the VA, we were only able to look if anybody had entered them into the electronic health record as a very specific order entry. Very few clinicians do that. So, we accounted for it; it didn’t change anything but we didn’t have outside medication data.

Maria Hecht: So, is there specific long-term outcome of this work that you would like to see, you know, in an ideal world?

Amy Linsky: I think the balancing act is that there’s been a lot of efforts to both automate healthcare systems to make things more efficient, right? So, let’s assume a medication is written as a 90-day supply with three refills; that those medications are renewed and sent to the patient to try it on a more systematic level.  
  
Simultaneously, we also want to push for medication adherence and having patients take the medicines. One of the prerequisites is that they have them in hand.  
  
And so, this balance between making it more efficient in terms of delivering the healthcare – in this case, medications – as well as promoting the patient aspect of taking those medicines as prescribed, I think, also needs to be balance with potentially oversupply.   
  
In this particular case, there’s a couple of things, both from my clinical experience and some of the things that we saw with respect to the research findings, that may potentially be able to help address this. These have not been tested out, per se, but have been looked at in other systems.   
  
So, a couple things where we know that patients who had care at more than one facility or by multiple providers were much more likely to have this medication excess.   
  
Currently, the way that the electronic health record is set up and clinical privileges are granted, you can only write orders for your own facility. You cannot write orders, and that also includes discontinuing orders, at any facility.   
  
So, while I can see what is happening as a clinician across the country, that the patient may have had medications filled 80 days ago – or let’s go with the insurer time, 20 days ago – I can’t actually change those orders or stop those orders. And I think that there should be some systematic way, as opposed to currently, a little bit less formal mechanism to communicate with those other sites in a streamlined process that would discontinue orders remotely so that patients can only get medications from one site or from one provider.  
  
I think another issue that we found in the study was that patients who had combinations of medication duration. So, a lot of times, meds are written for either a 30-day supply or 90-day supply. And we took a look to see what proportion of a patient’s medications were being filled as 90-day versus 30-day or some combination of the two. And not surprising, the patients who had a combination of these durations were much more likely to end up with overlap or medication excess.  
  
And it makes sense. So, I don’t think that anything was very surprising. These are the patients who are having their doses adjusted, they’re having new medications started. You don’t want to give them a 90-day supply until you know they’re stable.   
  
But then, once they are stable and you switch them to a 90-day supply, that medication might be off-sync in terms of the timing of when it needs to be refilled. So, you could have three medicines that are all being filled on March 1st; another medicine that needs to get refilled on March 20th; another medicine that gets filled on April 10th; and it gets very complicated and much more likely to have some of these problems clinically.   
  
Whereas if we could say, “Okay, well, this patient needs 18 days to bridge them to get them on the same exact schedule with their other medicines,” I think we need to have some way of doing that that doesn’t cost anything to the patient. Because they would have to pay a copay right now as far as from a clinical standpoint if they have copays.   
  
So, I think some way of trying to align their fill dates would also be beneficial so that everything is – you’re able to get people on all 30-day or all 90-day, or at least concurrent refills.

Maria Hecht: Is this something with the implementation of VA’s new updated electronic medical record that you see an opportunity to build in?

Amy Linsky: I mean, I think it would be great if this was something that we could do. I think it would be more than just the electronic health record because it would go into who has the rights or the privileges to discontinue orders at a remote site.   
  
So, it is possible that we can maybe use the new electronic health record to communicate between sites and have some system, maybe whether it’s through the pharmacies at each site, to discontinue those duplicate orders.  
  
With respect to the synchronization, again, maybe the IT system can help with that. But like we’d also have to implement some sort of policy that patients get like a free pass on the one time necessary to get them realigned in terms of having any copay, if they are required to pay copays.

Maria Hecht: So, you are a clinician. What does that bring to your work personally and professionally?

Amy Linsky: I see patients in primary care one day a week. I’ve had some patients I’ve been seeing for over 11 years now, which is crazy to me to think about.

Maria Hecht: That long-term relationship must be really rewarding.

Amy Linsky: It is. And it’s the reason why I went into Primary Care, which is also somewhat interesting. I remember being very reserved, very shy in college when I was thinking about medical school. I remember my mom saying, “Well, you can be a pathologist or a radiologist. You don’t have to talk to people that way.”   
  
And honestly, the best part of the day is when I might even have a little bit of extra time and I can just sit and talk with the patients and hear about whatever travels are going on or something that’s more personal. We can actually have conversations, not about necessarily the patient-provider dialogue that’s happen.   
  
It always sometimes surprises me, I think, still at how much patients will just trust me, what they will share me. And that, I think, is incredibly grounding and also, puts some of the research on other stressors a little bit more in perspective when you’re dealing with patients’ physical and mental health and wellbeing.   
  
So, yes. So, I think it is a great experience. I never expected to be practicing within the VA. I love it, definitely recommend it to others, and I think that the clinical aspect definitely feeds into my research questions and vice versa. I like wearing those two different hats.  
  
With respect to my research area, is really thinking about the judicious and appropriate use of care. Really, the more is better is not the way that I think. Clinically, as a practicing – definitely not in my research studies – time is a great healer of things. Sometimes just sitting and waiting is a good thing to do, and really looking at ways that we can improve the comfort that both patients and clinicians have with just kind of holding back and seeing what can be done without medications or interventions.

Maria Hecht: The views and opinions expressed in the preceding podcast are concerned with the scope of recently concluded or ongoing VA HSR&D-funded research and do not necessarily reflect current or to-be-implemented VA policy.   
  
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