The Price of PEACE

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Of course, real peace is priceless. Seeking true peace is at the center of our Judeo-Christian heritage. Alas, I am not speaking about this kind of peace, but rather I am referring to the hard work of a team of persons at Jefferson University Hospital, or the Pharmacoeconomics and Cost Effectiveness (PEACE) Committee.

I’ve written about the PEACE Committee several times before, including over a decade ago when this committee was first formed, and in December 2015 in these pages. So why resurrect the “price of PEACE” today? Drug costs are rapidly becoming a target for investigation at the national level, and our growing clinical delivery system is facing some critical upcoming decisions.

First, an update about Jefferson Health. Our system has grown to a $4.2-billion clinically integrated system comprised of Abington Health, Aria Health, Jefferson Health, and, soon, Kennedy Health. We will soon be one of the largest regional providers of care, with tens of thousands of our own employees. On our campus in Center City Philadelphia at Jefferson Health, contiguous with our College of Population Health, pharmacy services are delivered in multiple settings, including the acute care area, ambulatory infusion centers, retail pharmacies, and a robust home infusion program.

In fiscal year 2016, our acquisition costs at Jefferson Health alone for acute care drug spending only topped out at more than $59 million. I’d like to explore some of the key categories that made up this purchase price, but here is the punchline—we have 1 particular class of drugs with a more than $5-million annual price tag, and another 5 drugs, each with more than $1 million. So right there is $10 million of the total $59 million of annual spending. How did we reach this point, and what is the role of this important PEACE Committee in trying to respond to the cost challenge?

As I wrote back in 2005, our top drug acquisition cost category, at more than $5 million, is for drugs related to coagulation factor 7A. The total category of drugs for the management of blood formation, coagulation, and thrombosis is nearly $12 million. It has been more than a decade since the antihemorrhagic agents have been restricted to a subspecialty use, and yet this use continues to increase inexorably. I see a significant future challenge in a world of bundled payment, or global capitation. How will we contend with drug costs at this level? This remains unanswered at this time.

Not surprisingly, the second largest spending category is on the therapeutic class known as “antineoplastic agents.” Because we are part of a nationally recognized cancer center, a good part of the admission profile to our university hospital involves quartenary care for individuals with cancer. We will be paying particular attention to the therapy of patients who have multiple myeloma, because this has been an explosive area of new drugs (4 new drugs approved in 2015) and the associated overall cost of care.

The next category, the “anti-infective agents,” has a total price tag of more than $6 million, of which the top drugs are daptomycin (Cubicin) and linezolid (Zyvox). When I was in training, these drugs did not even exist! In addition, when I joined Jefferson 25 years ago, this class of anti-infective agents was by far the center of our largest category in terms of drug acquisition costs.

The fourth category, which are known as “central nervous system agents,” had a total acquisition cost in fiscal year 2016 in excess of $5 million, representing a nearly 30% increase over the previous fiscal year. A deeper dive into this category reveals that antimanic agents, antimigraine agents, and even general anesthetics continue to have double-digit increases in price. Finally, the opioid antagonists also increased dramatically in price and total units purchased, which is a reflection of the opioid epidemic nationwide.

Having now described these top 4 categories, let us shift our focus and examine the 5 individual drugs with an acquisition cost, each, in excess of $1 million.

The 5 agents, each with an acquisition cost of more than $1 million (in addition to the $5 million we spend on coagulation factor 7A), are, in decreasing order, carmustine, daptomycin, immunoglobulin, lymphocyte immune globulin, and bupivacaine liposome. Although their specific use is beyond the limits of this editorial, I do wish to mention one specific thing about bupivacaine liposome.

Within the purview of the PEACE Committee is an opportunity to provide detailed cost information in a
timely manner to the hospital administration. Although it is possible to argue about the weight of the evidence, and the overall efficacy and effectiveness of bupivacaine liposome, our PEACE Committee took a bold stand and made an urgent recommendation to the Pharmacy & Therapeutics Committee itself, to remove this drug from the formulary. This is in the setting of an institution where leading anesthesiologists conducted some of the key clinical trials when this agent was first brought to the market.

I am not going to weigh in on the arguments—pro and con—except to report that the PEACE Committee acted swiftly to essentially remove one drug from the formulary that carries an acquisition cost in excess of $1 million in response to a leadership mandate to reduce our overall drug acquisition costs. I believe we are going to see more rapid action such as this, which will no doubt be upsetting for physician investigators across our delivery system as we struggle with a pharmacy budget that is simply untenable.

I believe it is unlikely that the PEACE Committee will declare “peace” anytime soon. As our multibillion-dollar delivery system begins a rigorous process of self-evaluation and implementation of guidelines regarding pharmacotherapy, we are going to discover additional challenges. For example, early review of the formularies across the 4 principal hospitals—Abington, Aria, Jefferson, and Kennedy—reveals modest overlap.

This presents a serious challenge, because each institution will now have to “look in the mirror” and make some difficult decisions about care coordination, practicing based on the best available evidence, and giving doctors better information about their own work. This is what true clinical integration is all about.

As a result, I see the work of this important committee as central to the mission of delivering safe and effective patient-centered and equitable care deeper into the twenty-first century. The “price of peace” is vigilance, requiring constant scanning of our environment. It also means that clinicians must be at the center of this process, and lead as appropriate.

As always, I’m interested in your views. Does your clinically integrated network have a PEACE Committee, or something akin to it? How are you dealing with drugs that have more than a $1-million acquisition cost? I am always interested to learn about progress within your center; you can reach me via e-mail at david.nash@jefferson.edu.

References