

## LETTER TO THE EDITOR

### Transforming the P&T Committee

*To the Editor:*

I would like to follow up on (and lend my support to) an editorial by David Shulkin, MD (“Reinventing the Pharmacy and Therapeutics Committee”). In the November 2012 issue of *P&T*, Dr. Shulkin wrote, “As value-based reimbursement and accountable-care models drive us into an era focused on cost-containment and care-management strategies, the P&T committee must evolve—in fact, reinvent—itsself.”

As a former chairperson of a P&T committee at a large community teaching hospital, my colleagues and I recognized that we needed to focus not only on the clinical and financial impact of drug therapies but also on treatments that could be used instead of drugs. Our institutional review board was approving studies of medical devices and technology that would have an impact on surgical procedures and the use of drugs. Given the hospital’s siloed budgeting process, we needed to explain how cost-shifting might occur in patient treatments and why our budget for drugs could be higher than that of comparable hospitals. In addition, if medical devices and other technology were granted FDA approval, they would not be part of a P&T committee review. The value analysis committee would evaluate these products, but would they compare all patient treatments for efficacy, clinical outcomes, safety, and overall costs of treatment?

Most P&T committees report to a medical executive committee, whose members look over minutes from multiple meetings. However, no single committee is reviewing the data on outcomes, safety, or costs of various therapies.

P&T committee members look at efficacy, safety, and the pharmacy budget, as well as the impact on every other department within the hospital or health care system. They also consider the cost of laboratory and blood bank procedures, hospital length of stay, 30-day readmission rates, and even patient admissions. Sometimes a more expensive drug results in the best overall improvement in care and the greatest cost savings to patients, the health care system, and the accountable care organization (ACO). At other times, the expensive drug might not be the best option.

Hospital personnel from the Finance Department, as well as from Performance Improvement and Quality, need to join P&T committees to assist in measuring the impact of cost of care. Hospitals have moved away from episodic-care and reimbursement models to continuum-of-care, ACO, value-based, and shared-success plan reimbursement models. P&T committees would fit perfectly into the ACO model, because they have always been accountable for patient care, clinical outcomes, and financial decisions.

P&T committees should be reviewing drugs, medical devices, blood products, and possibly even surgical procedures and determining the best treatments, outcomes, safety, and the cost of each treatment. Currently, no one committee in the hospital has oversight, and decisions should not be made in a vacuum.

In the ACO patient-treatment model, comparative effectiveness should be incorporated and pharmacoeconomics should be replaced. The P&T committee should be transformed into

a comparative effectiveness (CE) committee, with subcommittees on value analysis, nutrition support, and hematology and transfusions. As more health care systems begin to offer their own insurance plans, the CE committee could review all potential therapies for efficacy, safety, and cost. Acute and non-acute care patient treatments, including those in the medical home, would be addressed. Some value-based insurance health plans may already be steering selected patients toward a particular treatment guideline or algorithm, and payers are conducting retrospective reviews of treatments. A CE committee that is an integral part of an ACO can analyze the efficacy, safety, and costs of treatment and, at the same time, assess clinical outcomes to promote the best care for patients.

Sincerely,

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