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Cleveland Clinic Saves $22M in Pharmacy Costs By Developing Dashboard Tool

By Laura Ramos Hegwer

Cleveland Clinic's 2016 prescription drug savings were the result of improved pharmacy sourcing, new technology developed in-house, and greater visibility into drug price changes.

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+ supply chain +

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By Laura Ramos Hegwer

After identifying a spike in the cost of a particular drug, the health system's inpatient clinical pharmacy team adjusted the formulary, resulting in $50,000 to $80,000 in savings.

As hospital pharmacy costs continue to rise, leaders at Cleveland Clinic have developed several cost-saving strategies, including a homegrown dashboard tool that helps the pharmacy sourcing and purchasing team monitor drug price increases.

Working Within the Prime Vendor Model

"Historically, pharmacy has always struggled to evaluate the impact of price increases," says Jeff Rosner, senior director, pharmacy sourcing and purchasing. One reason for this is the nature of the prime vendor model. In this model, organizations like Cleveland Clinic purchase 90-95 percent of all drugs through a drug wholesaler or distributor, which acts as the intermediary between providers and manufacturers. "It is an efficient process because we don't have to send out multiple POs [purchase orders]. Instead, we can send one PO that will cover hundreds of products. The distributor also acts as a financial intermediary to make sure that our prices are correct."

But the prime vendor model has its shortcomings, particularly for providers trying to track changes in drug prices. "Unfortunately, the distributor does not normally disclose all price changes, nor does it do so in an efficient manner," Rosner says. But even having access to the cost data is not enough to determine which price changes—of potentially hundreds or thousands of products at once—are the most significant to the bottom line.

In 2016, leaders at Cleveland Clinic fully implemented a dashboard and a new process to help them respond to drug price changes more effectively. Ultimately, it was headline-making price increases from several drug companies that spurred Rosner's team to take action. "We didn't want to rely on media reports or ad hoc communications from our peers or elsewhere to identify these products and then to manually determine the financial implications of those changes," he says.

Visualizing the Impact Today

Using an interactive dashboard, Rosner and his team can track all 40,000 products they are purchasing through their prime vendor. Rosner's team developed the dashboard using a commercially available data visualization tool. The tool integrates electronic price catalogs provided by suppliers with Cleveland Clinic's pharmacy purchasing data warehouse to identify price changes coordinated with product usage. Approximately twice a month, the team updates the product catalogs from the distributor and uses the dashboard to check all items that have changed price. Before each dashboard goes "live," the team engages in a quality assurance process to correct any extreme price increases or decreases that might be related to unit-of-measure inaccuracies (such as a difference in dosages or product sizes) or similar issues after loading a new price catalog.

On the dashboard, the drugs are listed by their National Drug Code (NDC) description and ranked in descending order according to their annual impact based on current use. The dashboard also shows the impact by operational region and facility site. The tool can filter by specific products and manufacturers to help staff identify where price changes are originating.

Yet what really matters is how the team takes action after noting meaningful drug price increases. Specifically, pharmacy purchasers can evaluate alternative products that could be used instead of higher-priced products. It also gives the team some negotiating leverage.

Soon after the new process was implemented, Rosner and his team identified a price increase in an IV gout medication that had previously been "flying under the radar," he says. "With that spike in cost, we would have had to absorb a significant increase, so we went to the inpatient clinical pharmacy team, and it adjusted the formulary to switch to another product that was significantly less expensive." This resulted in approximately $50,000 to $80,000 in savings.

When appropriate alternative products are not available for most patients, the pharmacy team negotiates directly with manufacturers for better prices. When that isn't successful, the clinical pharmacy team develops protocols that allow the hospital to mitigate a good portion of the increase, Rosner says. That was Cleveland Clinic's strategy when the price of nitroprusside sodium, an antihypertensive, increased by more than 500 percent. Team members also found ways to eliminate waste by sending smaller quantities to the floors without compromising patient safety.

More recently, when the price of one contrast agent—a substance used in imaging to enhance the contrast of bodily structures or fluids—increased 70 percent over the previous year's pricing, a member of the pricing team contacted the manufacturer to renegotiate for a better price. They also asked the clinical pharmacy team about an alternative product that, although it was in short supply, might be substituted when it became available.

Such initiatives, primarily driven by the inpatient side, can lead to significant cost savings. "We look at different pharmaceutical agents that are clinically equivalent, negotiate with manufacturers for discounts, and then ultimately put only one of those products in our formulary or give it a preferred status within the formulary," he says.

Rosner says it is difficult to track cost savings resulting from the tool alone. That said, the organization was able to reduce its overall pharmacy spend by more than $22 million in 2016. The organization also can use the tool to retrospectively review prices of high-volume expensive drugs and compare them with budget forecasts.

Currently, the drug-pricing dashboard is only in use at Cleveland Clinic.

Lessons Learned

Rosner offers the following advice for healthcare leaders who want to reduce pharmacy costs in their organizations.

Foster collaboration between the finance and pharmacy teams. "CFOs and pharmacy leaders are seeing pharmaceutical spend grow considerably," Rosner says, pointing to the rising cost of specialty and orphan drugs as an example. "Every month, there are some significant year-over-year increases on the pharmaceutical line. So finance can work with the pharmacy directors and chief pharmacy officers within their organizations to identify key drivers of their pharmaceutical budget and what they can do to mitigate some of those increases."

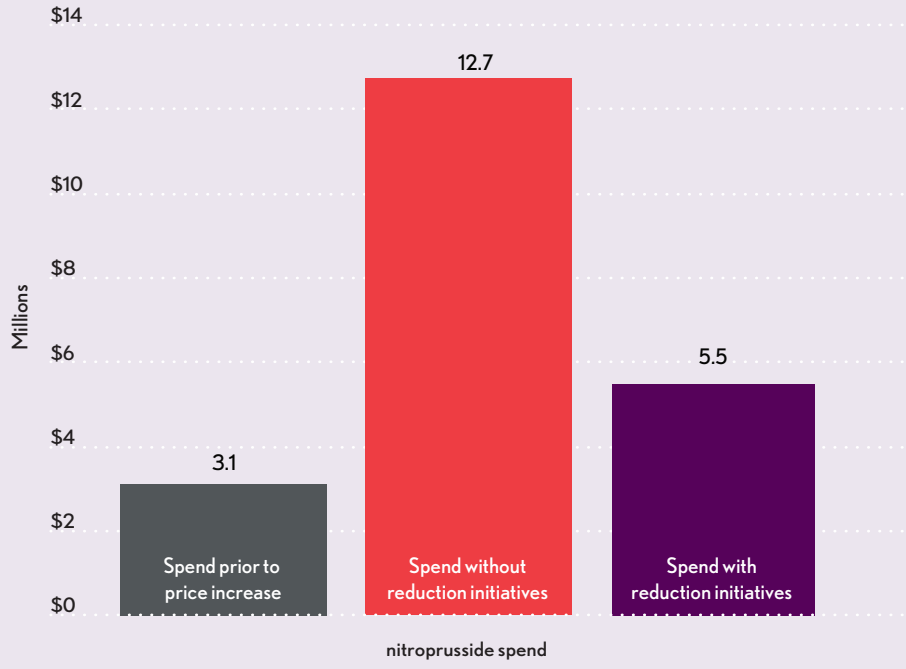
Work with your group purchasing organization (GPO). "We are fortunate to have a sophisticated pharmacy and supply chain team," he says. "Other hospitals, particularly smaller hospitals, don't necessarily have those resources. But GPOs can provide access to tools and information that can help."

Be aware of the market. This includes not only headline-making price increases, but also smaller increases. "A 5 percent increase can have a million-dollar impact in terms of increased costs," he says.

Consider the possibilities of biosimilars. Rosner's team is also looking at biosimilars

Response to Drug Price Increase Saves Cleveland Clinic $7.2M

Leaders at Cleveland Clinic identified strategies to mitigate the impact of the price increase of nitroprusside sodium by $7.2 million.



Source: Cleveland Clinic, Cleveland. Used with permission.

that can be used in place of high-priced biologics. Typically, these products are priced at least 20 percent lower than the original, "reference" biologic. More biosimilars are expected to come through the pipeline in the United States over the next several years.

There is nothing like grassroots involvement to help inform federal and state legislators to drive change.

Don't be quiet about pricing issues. "We have been very successful elevating the awareness of pricing issues by working with media relations and our government relations teams," Rosner says. "There is nothing like grassroots involvement to help inform federal and state legislators to drive change. We want to keep the awareness up so we can have pharmaceutical price increases that are more consistent with the general inflation rate."

Looking Ahead

To expand its cost-savings strategies, Cleveland Clinic has partnered with a member-owned healthcare services company to develop its provider-led GPO. "It's a niche GPO that specializes in physician preference items such as devices and implants," he says. "We see a growing opportunity for pharmacy to help GPO members understand some of the clinical work we have done in health technology assessments on pharmaceuticals, just like we are sharing that information on med-surg products like implants." +

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The Cost of Delaying the Move To Value-Based Care

By Ty Tolbert

In 2017, the pace of value-based care will accelerate. A calculation tool can help providers make the case for action.

While the Trump administration likely will bring a host of changes to the healthcare industry, many analysts don't expect it to significantly slow the shift from fee-for-service to value-based care models.

For example, Tom Price, the new U.S. Department of Health and Human Services Secretary, is on record as desiring to simplify, not end, value-based care models. He favors voluntary bundled payment models over mandatory ones. He also has said he will consider new models put forth by language already passed into law and within pending bills like the Chronic Care Act, which seeks to expand telehealth benefits to current Medicare accountable care organizations.

Overall, the rising cost of healthcare services makes it unlikely that the Centers for Medicare & Medicaid Services (CMS) or private payers will abandon the trend toward shifting more risk to providers under quality reporting programs. CMS exceeded its 2016 goal to tie 30 percent of Medicare payments to alternative payment models (APMs), and it is on track to meet its 2018 goal of having 50 percent of its payments in APMs.

Although the implementation schedule of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) was modified to a slower pace based on provider feedback, its launch this year accelerates the need for providers to understand what they stand to gain and lose by participating—or not—in APMs. The first performance period of the Quality Payment Program (QPP) under MACRA launched in January 2017. Most providers will participate in the Merit-Based Incentive Payment System (MIPS) track of QPP, where they can earn a performance-based payment adjustment. Nonparticipating providers will be penalized with a 4 percent negative adjustment to their compensation.

Private Payers Playing a Bigger Role

In addition to federal government initiatives, commercial payers are creating new incentives for providers to participate in APMs. Humana is one private payer that has most embraced this trend, claiming that more than 60 percent of its membership is served by nearly 50,000 providers in a value-based care model.

Most providers will participate in the MIPS track, where they can earn a performance-based payment adjustment.

A growing number of public-private partnerships also are underway. For example, the Comprehensive Primary Care Plus (CPC+) program, which will include more than 13,000 primary care clinicians in 14 regions and will serve more than 1.76 million Medicare beneficiaries, with 54 aligned private payers, will offer participating providers a monthly care management fee plus a performance-based incentive payment.

Although most providers are aware that these programs will affect their compensation, it can be challenging to project the impact on the bottom line. To help organizations predict this impact, a free tool called the Cost of Inaction (COI) Calculator (https://www.wellcentive.com/cost-of-inaction-calculator) demonstrates the cost