The Source

HEALTHTRUST

A QUARTERLY NEWSLETTER FOR PHYSICIAN MEMBERS OF HEALTHTRUST

Fall 2013

The Critical Intersection of Cost, Quality and Outcomes

With the changing dynamic between providers and physicians, there's never been a more critical time for physician leaders to collaborate with supply chain in creating the balance between patient care and financial stewardship. Bridging the gap between patient care and financial stewardship was a topic of discussion during last month's Physician Steering Committee meeting as well as a panel open to all attendees during the HealthTrust University Conference & Vendor Fair (HTU). Special thanks to physician committee members Lanny Copeland, Lou Fierens (with Paul Conlon), Steven Manoukian, Barbara Paul, Ronald Riner and Ed Septimus for their participation on the panel, as well as to Eric Louie, M.D., chief medical officer of Sg2, for his presentation.

Some of my remarks at the HTU general session focused on how, in the new marketplace reality, supply chain finds itself at the critical intersection of cost, quality and outcomes. Physician engagement at both the system and facility level can provide supply chain leadership with the most value in creating shared direction and strategies for savings initiatives.

In the months ahead, HealthTrust will encourage ongoing dialog with practicing physicians at our member facilities. Together, we will determine how to maximize physician engagement to align on initiatives and share scalable best practices that could possibly inform treatment protocols in evolving care models. We are proud to represent many of the nation's most respected healthcare providers in our membership and we look forward to implementing solutions that protect the clinical core while reducing expenses.

Ed Jones, *President and CEO*

HealthTrust Physician Steering Committee

Lanny Copeland, M.D., ***LifePoint***
Michael Cuffe, M.D., ***HCA***
Steven Manoukian, M.D., ***HCA***
Stephen Moore, M.D., ***CHI***
Terry O'Rourke, M.D., ***Trinity Health***
Ronald Riner, M.D., ***HMA***
Edward Septimus, M.D., ***HCA***
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Please let us hear from you.

Email your feedback and ideas for future stories to: **Lynn Tarkington**, AVP, HealthTrust physician liaison, at **lynn.tarkington@healthtrustpg.com**

Competitive Biologics and Biosimilars

The Current and Future Landscape

By Kara Fortune, PharmD, director of HealthTrust Pharmacy Services

In the current healthcare market, there is a conflict between the desire to provide improved access to better medicines and the need to limit the growth of healthcare expenditures. The use of biologics is an essential element in cancer treatment and supportive care. Biologics include growth factors, monoclonal antibodies (MAbs), therapeutic proteins and immunomodulators. Global biologic drug sales are expected to reach nearly $200 billion by 2015, up from $138 billion in 2010. Currently, just under half of biologic drug spending is concentrated in the United States.

The patents of many biologics are approaching or have reached expiration, and biosimilar drugs are expected to bring about a cost savings of 20-40 percent once regulatory guidelines are determined. Balancing the needs of the relevant stakeholders is critical to ensure patient safety while controlling costs, improving access and encouraging innovation.

Definitions and FDA Review Process

The term "biosimilar" has been used loosely to describe any follow-on biologic drug whose target is the same as that of an originator biologic drug. The Biologics Price Competition and Innovation (BPCI) Act establishes an abbreviated approval pathway for biological products that are demonstrated to be "highly similar" (biosimilar) to or "interchangeable" with an FDA-approved biological product after a period of 12 years of exclusivity for the originator biologic.

Despite the abbreviated pathway for biosimilars having been signed into law, the Food and Drug Administration (FDA) has yet to issue finalized practical guidance. To date, the FDA has received 14 biosimilar applications.

HealthTrust uses the term "competitive biologics" to define products approved by the Biologic License Application (BLA) pathway with these characteristics:

- FDA-approved, non-originator biologic that is molecularly similar to the originator biologic
- Product has undergone extensive clinical vetting by HealthTrust
- Product has been placed on contract to specifically compete in a GPO market space traditionally held by an originator biologic

Most recently, Teva's Granix (tbo-filgrastim), known as the biosimilar Tevagrastim in the European Union, received U.S. approval under the BLA route since a biosimilar approval pathway had not been established at the time of submission. This product is an example of a U.S. competitive biologic. Tbo-filgrastim, the first new granulocyte colony-stimulating factor (G-CSF) to be approved in the U.S. in more than 10 years, is expected to launch in November 2013, and be available for use in December 2013. Tbo-filgrastim is a short-acting recombinant form of G-CSF, indicated to stimulate neutrophil production in adults who become neutropenic while undergoing chemotherapy for nonmyeloid malignancies. In the efficacy study of tbo-filgrastim, the effectiveness was determined based on study results that showed that patients receiving tbo-filgrastim recovered from severe neutropenia in 1.1 days compared with 3.8 days in those receiving placebo. The approval of tbo-filgrastim offers physicians and their patients undergoing chemotherapy a new supportive care treatment option.

Manufacturing Complexity

Biosimilars are much larger in size and more complex than small molecule drugs that can be identically synthesized. Since biologics originate from living organisms, follow-on biologic manufacturers cannot guarantee that their product is completely identical (generic) to the originator product. Brand-name biologics have always been variable from batch to batch and after manufacturing changes. In fact, a biosimilar will be as close to the brand originator product as the originator product is to itself chemically, structurally and functionally between lots. The European Medicines Agency (EMA) and FDA agree that it must be demonstrated that any differences observed during the physiochemical characterization of the biosimilar candidate not result in meaningful biological or clinical differences in the performance of the biosimilar to ensure safety and efficacy. FDA regulations ensure that biosmilar manufacturers will demonstrate consistency and control over the manufacturing process, just as is required for originator products today.

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Immunogenicity and Pharmacovigilance

One of the biggest focus areas for the FDA regarding biosimilars is immunogenicity. Biosimilars are required to undergo extensive "fingerprint-like" analytical comparisons with the originator product before being tested in animals or humans. A robust pharmacovigilance program, able to capture clinically relevant immunological responses during real-world use of the biologics, is the proposed method to detect clinically relevant immunogenicity problems.

The amount of premarket and postmarket immunogenicity data needed for a potential biosimilar will depend on an analytical assessment of similarity between the biosimilar and its originator product, as well as the rate of clinical consequences of immunogenicity observed with the originator product.

Conclusion

HealthTrust recognizes the cost savings opportunity the market introduction of biosimilars/competitive biologics will potentially bring to its membership. The Biosimilars/Competitive Biologics Initiative is based on optimizing both clinical and financial outcomes with the use of these agents. For HealthTrust to optimize utilization and savings of these product entrants, it will be essential that members are fully engaged in order to fully optimize the value of this emerging market opportunity.

To find out more about competitive biologics and biosimilars, visit http://healthtrustpg.com/biosimilars.

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Update on August Physicians Steering Committee Meeting

The HealthTrust Physicians Steering committee meeting was held Aug. 19-20 at Opryland Resort in Nashville, Tenn., during the 2013 HealthTrust University Conference. Attendees heard updates from HealthTrust leadership, discussed ways of strengthening the physician/supply chain relationship and collaborated on ways to promote greater physician engagement.

The meeting began with the introduction of HealthTrust Chief Operating Officer Michael Berryhill. Berryhill and Fred Keller, vice president of Strategic Sourcing, discussed physician alignment and collaboration that led into a discussion of medical directorship. The group was given copies of the proposed charter and tasked with the challenge of creating goals for the coming year.

Berryhill asked committee members for their opinion on how physicians are best engaged, and there was discussion on how to standardize HealthTrust's current process and make it more robust. Steven Manoukian, M.D., believes there should be a "sliding scale" of physician involvement based on need. He said the group should lead with data that supports decisions and create the dialogue on how to leverage physician input. Edward Septimus, M.D., remarked that involvement in supply chain decisions should involve physicians to garner buy-in and engagement.

Lynn Tarkington asked their group for feedback and suggestions for upcoming topics for the *HealthTrust Physician Source* newsletter. Septimus requested that future editions contain highlights gleaned from national conferences and meetings, as well as newly published literature that could impact healthcare and practice.

April Simon gave a data analytics presentation and led discussion on how to access and utilize membership data in a meaningful and productive way. John Theobold and Kara Fortune from the HealthTrust Pharmacy team gave a presentation on biosimilars and competitive biologics (see story on page 2) and talked to the group about challenges in approaching facility physicians for clinical standardization around these products. The pharmacy team is facing hurdles in engaging specialized physicians.

Todd Lockhart and Cathy Crandall updated the group on advanced energy and electrosurgery equipment and supplies along with updates from the HealthTrust Surgery Advisory Board, and Allen Wright spoke to the group about HCA contracts on physician advisory services.

The final presenter was Eric Louie, M.D., chief medical officer for Sg2 Consultants. Louie talked to the group on competing and collaborating in a changing healthcare environment.

The Latest on Osteobiologics

Sorting through the pros and cons of spinal fusion surgery products

By Lynn Tarkington, RN, AVP of SourceTrust, and Michael Schlosser, M.D., FAANS, chief of staff, TriStar Centennial Medical Center

Spinal fusions are performed routinely in the United States, with an estimated volume of 614,000 in 2012 at an expense for hardware of nearly $7.2 billion dollars (Orthoworld, Inc., 2012). In certain types of spinal fusions, bone grafts are utilized as an adjunct to fusion. Surgeons may use bone grafting for a number of reasons, including in patients where bone healing may be difficult due to the use of nicotine (which has been shown in medical studies to limit healing of the spine) or the presence of diseases such as diabetes, malnutrition or autoimmune deficiencies.

Autograft, the use of a patient's own bone, is considered the gold standard in spine fusion surgery; however, not all patients have sufficient quantity or quality of bone for the best outcome. There may also be donor morbidity and pain associated with autograft harvest. Allograft bone, harvested from cadaver donors, is a common alternative to autograft.

Since both allograft and autograft have drawbacks, scientists have searched for materials—called osteobiologics—that could be used in place of the transplanted bone. There are more than 1,500 osteobiologic products from nearly 400 companies in the United States today, a market that represents $2.2 billion. Osteobiologics are used in many types of surgeries—orthopedic surgery, neurosurgery and plastic surgery, for example—but 84 percent are used in spine fusion surgeries. Most of these products are approved by the FDA via the 510K or HCT/P process and do not involve human clinical trials.

Investigators hope to find a material with three primary characteristics to enhance fusions: osteoconductivity, osteoinductivity and osteogenicity.

1. **Osteoconductivity** is the concept of a scaffold to support new bone formation, allowing for ingrowth of osteogenic cells into the graft site. This scaffolding is needed to bridge a critical gap and to improve speed of incorporation. Autograft, as the model of an ideal scaffold, has the needed porosity and is resistant to compression. Allograft bone products also provide for osteoconduction. Osteoconductive agents are coated with calcium phosphate, calcium sulphate or hydroxyapatite, and are useful when autograft or allograft scaffolding is not adequate. This category of products is often labeled as "synthetic" or "ceramic."

2. **Osteoinductivity** is the ability of the graft to induce or signal undifferentiated cells and osteoprogenitor cells within the marrow to initiate the bone fusion cascade, thereby inducing new bone formation. The initial inductive agents in this market are demineralized bone matrices (DBM). DBMs come from cadaver bone and are relatively inexpensive. Bone morphogenetic protein (BMP) is the other primary product with osteoinductive properties. BMP was approved by the FDA through its Premarket Approval (PMA) process as InFuse/Recombinant human bone morphogenetic protein-2, and it is marketed by Medtronic. InFuse is not osteoconductive by itself, and is sold in a kit with an absorbable collagen sponge. The approved indication is for procedures in skeletally mature patients with degenerative disc disease at one level from Lumbar 4 to Sacral 1 via the anterior approach utilizing the Medtronic cage.

There is significant scientific evidence of the efficacy of this product, but there are safety concerns resulting from overactivity of the same process that makes InFuse effective. The June 2011 issue of *The Spine Journal* challenged the published literature on InFuse, resulting in Medtronic giving a $2.5 million grant in 2011 to Yale University to conduct an independent review of all clinical study data as to the effectiveness

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and safety of the product. These analyses were performed by two independent academic teams who had full access to Medtronic's clinical trial, post-marketing and safety data. The reviews were published June 18, 2013, and may be found here. The authors concluded that in spinal fusion, InFuse was equivalent to autograft in fusion rates and outcomes; however, complication rates were higher in the BMP group. They also found that the risks of BMP outweigh the benefits in most clinical situations and that the evidence does not support the use of BMP in anterior cervical fusion in any situation.

"These conclusions were contrary to the original articles published on BMP," says **Michael Schlosser**, M.D., FAANS, chief of staff, TriStar Centennial Medical Center. "This serves as an example of the need for data transparency and the bias inherent in using only vendor-sponsored research to make decisions on spinal implants."

3. **Osteogenecity** is the ability of the graft to have actual pluripotent cells that can generate the healing cascade, direct bone formation and produce new bone. Autograft is osteogenic as it contains progenitor cells from the harvest site. The variability in quality and quantity of autograft harvest of cells can negatively impact the osteogenic properties. The scientific search for another osteogenic product has led to the explosive growth of cell-based allografts in the market. Often called stem cell products, these products come from either cadaver or live tissue donors. These products mimic autograft in promoting bone growth, with osteogenic, osteoconductive and osteoinductive properties. Cadaveric products are also called fresh frozen allograft or mesenchymal adult stem cell (MSC) products. The process for cadaveric donor bone includes retrieval, recovery of the MSCs and cryogenic preservation (freezing). Live tissue cell-based matrices are derived from placental and amniotic tissue donated by mothers at the time of birth. This tissue is processed and requires a carrier for use in patients.

There is a lack of scientific evidence suggesting these products' efficacy. Fresh frozen allograft products have some literature supporting their use; however, these products' superiority over fresh frozen cancellous bone chips has not been established. There is no clinical evidence supporting the use of live tissue cell-based products. The products are regulated as an allograft through the limited HCT/P process and are subject to FDA regulations outlined in 21 CFR part 127. These cell-based products are expensive.

"Stem cells may hold great promise in spine surgery, but they also raise new and completely different questions of safety and efficacy," Schlosser says. "The long-term effects of implanting living, foreign tissue in the spine needs to be carefully examined before the role of these products can be defined.

It is expected that osteobiologics' cost as an adjunct in spine fusion surgery will eclipse the cost of the hardware utilized in the procedure. Awareness and education for hospital leadership, physicians and staff is important, and each hospital should create a plan for action.

"As healthcare becomes more focused on value, there is great interest developing among spine surgeons in learning more about the evidence supporting the use of these products," Schlosser says."Several HealthTrust partner facilities have created physician-led committees to promote a more evidence-based approach to spine fusion. Careful examination of the best published evidence combined with outcome evaluation though a patient registry will help us stay on the cutting edge of treatment while managing the value of the surgery we perform."

For additional information about osteobiologics, please contact Lynn Tarkington at **lynn.tarkington@healthtrustpg.com**.

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The Cath Lab of the Future

SourceTrust Program to Assist with Cardiac Catheterization Laboratory Accreditation

By Robin Carneal, MSN, clinical director of SourceTrust, and Steven Manoukian, M.D., vice president of HCA Cardiovascular Services

Modern cardiac catheterization laboratories bear little resemblance to the cath labs of 10 years ago. There has been a shift in focus from diagnostic tests to catheter-based therapies, from coronary disease alone to the treatment of valvular heart disease, congenital defects of the heart and arterial disease in the legs, brain and other organs. An increasing number of medical centers are also developing hybrid cath labs that combine all the features of a multidisciplinary surgical suite with those of a cath lab, and technology has changed both the imaging and reporting systems. The lower risk of invasive procedures also has driven the expansion of cardiac catheterization laboratories to sites without onsite cardiovascular surgery backup and even to community hospitals where primary percutaneous coronary intervention (PCI) is now being performed.

"Today's cath labs are the cutting-edge destination for a diverse group of complex, high-risk and often hyper-acute patients, a trend that is likely to accelerate," says **Steven Manoukian**, M.D., vice president of cardiovascular services at HCA. "Today's state-of-the-art cath lab requires a well-defined quality improvement (QI) program to foster high-quality outcomes for the rapidly increasing pace of patient and procedural complexity. Effective strategies for enhancing cath lab care include physician engagement and leadership, a multidisciplinary team that includes C-suite representation, participation in national registries and consideration of cath lab accreditation by well-accepted agencies."

The basic components of an active quality assurance/QI system must include a committee with a chair and staff coordinator, a database and a means of data collection. There should be goals to eliminate outliers, reduce variation and enhance performance. To do this properly requires a serious commitment from facility administration and a QA/QI program committee that is active and aggressive regarding its responsibilities. (Bashore, 2012)

To address quality assurance issues for the cardiac cath lab, the Accreditation for Cardiovascular Excellence (ACE), a nonprofit initiative supported by the Society for Cardiovascular Angiography and Interventions and the American College of Cardiology, was formed about five years ago in response to Centers for Medicare and Medicaid Services' stipulations about accreditation for institutions performing carotid stenting. Approximately one year ago, ACE undertook the goal of providing accreditation for all invasive and endovascular procedures. ACE accreditation is a professional review of an organization's structure, internal processes, patient safety practices and clinical outcomes to determine if it meets the standards established by experts in cardiac and endovascular care.

In order to meet patient safety standards, appropriateness and quality metrics, the process of accreditation can be stringent, time-consuming and costly. "A proper accreditation initiative, which should be physician-led, needs to maintain transparency and consistency so all facilities are judged by the same standards. Much of the criteria to assess these physicians comes from training and competency documents, as well as data from clinical trials," says **Bonnie H. Weiner**, M.D., MBA, board chair and chief medical officer at ACE. "We not only examine staff credentialing activities, education activities and staff expectations, but we also assess the patient selection process, along with appropriate patient outcomes." (Cadet, 2011) To establish thresholds for the cath lab and PCI procedures, ACE utilizes clinical guidelines, appropriate use criteria and quality assurance documents.

HealthTrust, in partnership with Cardiac Data Solutions, Inc. (CDS), is preparing a service to help member facilities meet or exceed the ACE standards for cardiac cath lab accreditation. This service will provide an on-site assessment of the cardiac cath lab, consultative services to assist in identified areas of opportunity, necessary evidence-based tools and follow-up consultation as needed to ensure continued excellence.

Contact SourceTrust for more information and pricing for these services:

- Assessment and report
- Tools to assist in completion of online accreditation application and to pass accreditation
- Consulting assistance with implementation

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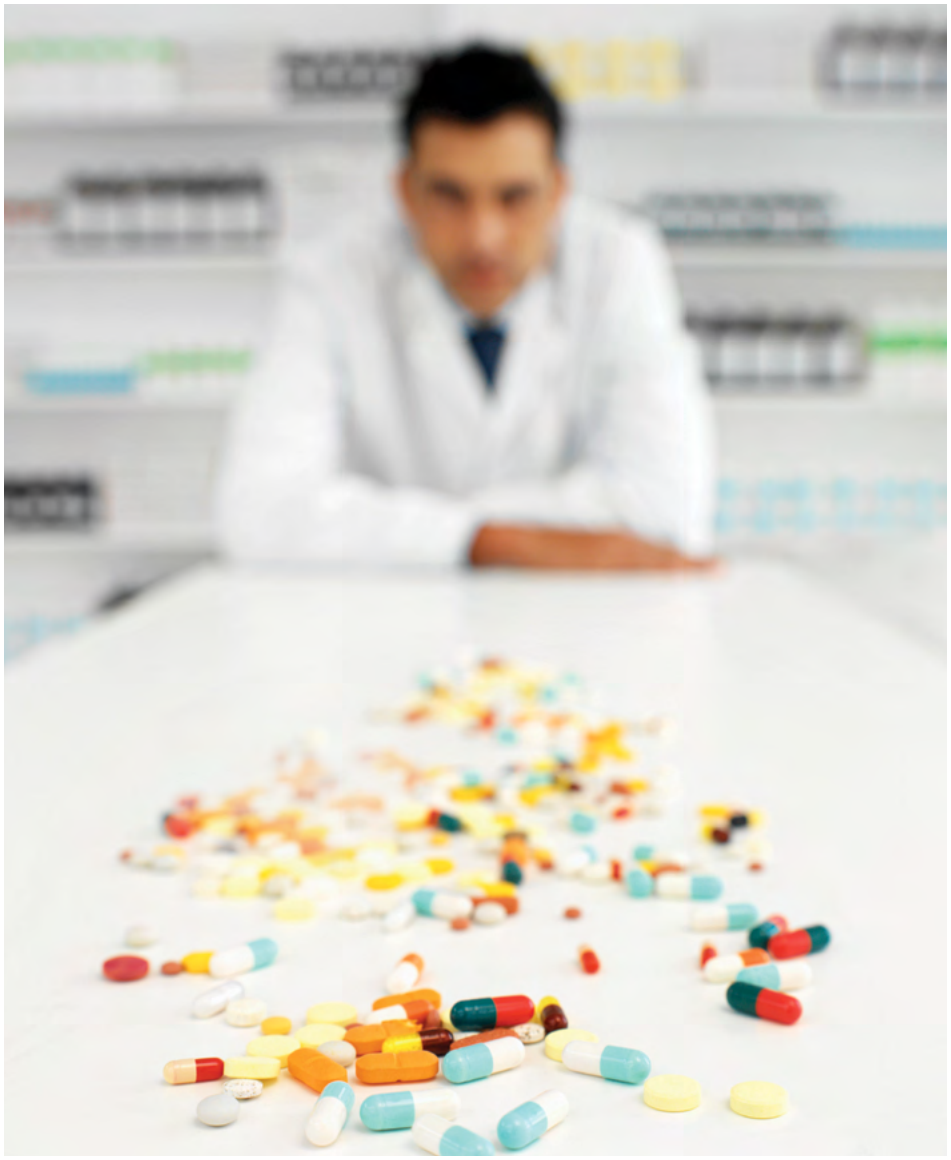
HCA's Breakthrough MRSA Study

Bloodstream MRSA infections cut by 44 percent in study of nearly 75,000 ICU patients



Edited by Edward Septimus, M.D., medical director of HCA Infection Prevention & Epidemiology

In January 2009, the Infection Prevention team at HCA embarked on a large-scale study to identify the best way to reduce the risk of methicillin-resistant Staphylococcus aureus (MRSA) infections. The study examined three different methods of treating MRSA in hopes of finding the most effective way to prevent and resolve MRSA and other healthcare-related infections. Research took place at 43 HCA facilities to determine if universal decolonization could effectively reduce bloodstream MRSA infections in ICU patients.

"This is both a human problem and a financial problem. Eighty thousand patients die of hospital-acquired infections every year, and about 20 percent of those were caused by MRSA. The only acceptable number of avoidable infections is zero," explains **Jonathan Perlin**, M.D., president, clinical and physician services and chief medical officer, HCA. "Beyond the human toll, the cost of the 1.7 to 1.9 million individuals who get healthcare-associated infections each year results in potentially unnecessary healthcare treatments that cost tens of billions of dollars."

The study, which took place in two stages from 2009 to 2011, involved nearly 75,000 patients and more than 280,000 patient days in 74 adult ICUs located in 16 states. "The size and magnitude of the trial was amazing," says **Edward Septimus**, M.D., medical director, infection prevention and epidemiology, HCA. "It was a tremendous collaboration that could potentially change the practice of medicine."

The study compared the results of a three-armed approach in ICUs:

1. Screen all patients and isolate MRSA carriers.

2. Targeted decolonization: screening, isolation and decolonization of MRSA carriers with an antiseptic soap (chlorhexidine) and a nasal ointment (mupirocin) for five days.

3. Universal decolonization: no screening and all patients decolonized with chlorhexidine and mupirocin.

The REDUCE MRSA (Randomized Evaluation of Decolonization Versus Universal Clearance to Eliminate MRSA) team found that using universal decolonization reduced MRSA clinical cultures by 37 percent, and all bloodstream infections were decreased by 44 percent.

"This study shows that for every 54 patients who were decolonized, one avoided the risk of an unnecessary hospital-acquired bloodstream infection. This has incredible implications for both the daily care we provide our patients and for the patients at other hospitals worldwide whose care will be improved as these facilities follow the protocol set by HCA and implement universal decolonization," says **Jane Englebright**, PhD, RN, HCA chief nursing officer, patient safety officer and vice president for clinical performance.

The findings suggest a major change in healthcare practice that could save lives. As a result of the findings, HCA is in the process of implementing universal decolonization in the adult ICUs of its affiliated hospitals.

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"It's important to point out that the study was largely conducted in community hospitals rather than academic institutions, and by hospital personnel rather than specially trained staff," Septimus says. "Therefore, unlike some clinical studies, this means the results are more generalizable and transferrable to hospitals in all areas. Any hospital should be able to do this."

"Once we saw the results of the study, we knew that as a company we needed to take this practice to all of our hospitals," explains **Jason Hickock**, AVP, critical care, infection prevention and laboratory. "We worked with the same internal partners, including our infection preventionists, pharmacists, critical care nurses, supply chain, project management, executive leadership and others to make sure that we implemented this same protocol throughout all of our adult ICUs."

The REDUCE MRSA trial was a collaborative effort. The study concept and design were created by investigators in the Centers for Disease Control and Prevention (CDC)'s Prevention Epicenter Program at the Harvard Pilgrim Health Care Institute, Harvard Medical School, Rush University, Washington University in St. Louis and the University of California, Irvine. The Agency for Healthcare Research and Quality (AHRQ)'s healthcare-associated infections program provided funding, and the research was conducted through AHRQ's Developing Evidence to Inform Decisions about Effectiveness (DEcIDE) network.

"BECAUSE THE TRIAL WAS CONDUCTED LARGELY IN COMMUNITY HOSPITALS, THE RESULTS ARE MORE TRANSFERRABLE TO ANY HOSPITAL."

— **Edward Septimus**, M.D., medical director of HCA infection prevention and epidemiology

The unprecedented partnership between public and private institutions was so successful that the *New England Journal of Medicine* published the study in May. Next, the Infection Prevention Team will collaborate to report on the cost savings of treating MRSA effectively. "We applaud the incredible work and results. However, on the cautious side, the next phase of the study will determine if the mupirocin or the chlorhexidine will engender resistance," Septimus says. "That part of the study is reaching completion."

For more details on the trial, visit www.cdc.gov/hai/epiCenters/new_research-reduce-mrsa.html, and for the CDC EpiCenters Program, visit www.cdc.gov/HAI/epiCenters/index.html.

Q&A With Lynn Simon, M.D.

Improving Quality by Strengthening the Hospital and Physician Engagement

Lynn Simon, M.D.

Neurologist Lynn Simon, M.D., is senior vice president and chief quality officer at Community Health Systems, which owns, leases or operates 135 hospitals in 29 states. Prior to that, she served as senior vice president, chief medical officer at Jewish Hospital in Louisville, Ky. Previously she was in private neurology practice in Louisville. She has an MBA from Bellarmine University in Louisville, completed her neurology residency at Stanford University, completed her internship at Rush University in Chicago and graduated from University of Louisville School of Medicine.

How has your role as a quality officer changed recently?

The role is much more aligned with hospital operations. Together, we're taking a more collaborative and progressive look at how we manage performance across a wide variety of metrics, some based on the various national quality-based incentive or penalty programs and others relating to specific service lines. The incentive or penalty programs include the Hospital Value-Based Purchasing (HVBP) Program, Readmission Reduction Program and the Hospital-Acquired Conditions (HAC) penalty.

In the past, what some people considered quality was driven by meeting process measures and accreditation standards. Today and particularly moving into the future, quality measurements are much more related to patient outcomes and value. The Centers for Medicare and Medicaid Services is reflecting this in its incentives and penalties. For example, in the HVBP program, higher weights will be given for outcomes measures like mortality and infection reduction. The cost of care will also enter more into the equation.

How do you help your hospitals make this shift?

Our role as a corporate quality department is to serve as a resource for hospitals and physicians to help them understand the new rules and to facilitate their improvement efforts. We do this by providing information and education and sharing best practices across the organization. We don't want people to wonder about how to fix a problem when we have the benefit of the shared knowledge of 135 hospitals. We host collaboratives that assemble a group of 10 to 25 facilities with a specific goal in mind, such as how to improve infection rates, reduce readmission rates or reduce patient falls. These collaboratives review literature, talk about what works, share best practices and discuss what drives change in their particular hospitals. You don't have to reinvent the wheel; you can implement large-scale improvements by strengthening hospital collaboration.

What about similar programs related to quality targeted to physicians?

The PQRS (Physician Quality Reporting System) and the Value-Based Purchasing Modifier (VBPM) are measures that are starting to impact Medicare reimbursements for physicians. The PQRS is somewhat equivalent to hospital core measures. VBPM is similar to hospital value-based purchasing, which looks at the quality (using PQRS measures) and cost of care provided by a physician or physician group.

If physicians do not report PQRS measures in 2013, they will have a small (0.5 percent) penalty applied to their Medicare payments in 2015. VBPM starts in 2013 for large physician groups (greater than 100 providers) and will affect payments in 2015. Other physicians will be brought into the program in subsequent years.

Our role is to help engage physicians in the performance of the hospital where they practice, as well as help them meet the requirements of the physician programs and prepare for the future. These programs will drive all of us to provide better quality and lower costs (i.e., improve overall "value").

How are new payment penalties and incentives for both hospitals and physicians improving quality and reducing costs?

The transparency of the data has created focus and priorities. It has provided an additional platform to bring hospitals and physicians together to discuss reducing infection rates and reducing readmissions, for instance. Hospitals were looking at this before, but the transparency has driven some of that collaboration. Plus, having so much tied to reimbursement puts a somewhat different slant on things. With the Readmission Reduction Program, hospitals are penalized for "excess" 30-day readmissions for AMI, heart failure and pneumonia. In FY 2015, COPD and hip and knee arthroplasty will be added. And with hospital-acquired conditions, starting in FY 2015 hospitals will be penalized if they are in the worst performing quartile in the nation on patient safety indicators and infection rates.

To lower readmission rates, hospitals have to partner with and coordinate care with physicians, other clinicians, long-term care facilities, therapists and home health providers. It causes people to look at longer-term outcomes and the collaboration needed to achieve that. This may involve discharge phone calls to patients to make sure they have the medicine they need and access to faster follow-up care. The incentives with hospitals and physicians are starting to align to help ensure more coordinated care.

What challenges are new physicians facing?

One of the challenges of having an independent practice is managing the complexities, such as adopting meaningful use of electronic health records (EHRs) and meeting reporting and regulatory requirements. Hospitals and physicians have incentives to implement EHRs, but the incentives don't cover all the costs of this evolving technology. Plus, physicians face a learning curve with EHRs. The hope is that EHRs will make us more efficient and provide better care—but this is yet to be realized.

So practicing in today's environment is advantageous in many ways, including better technology and access to information, but meeting all the new requirements is challenging.