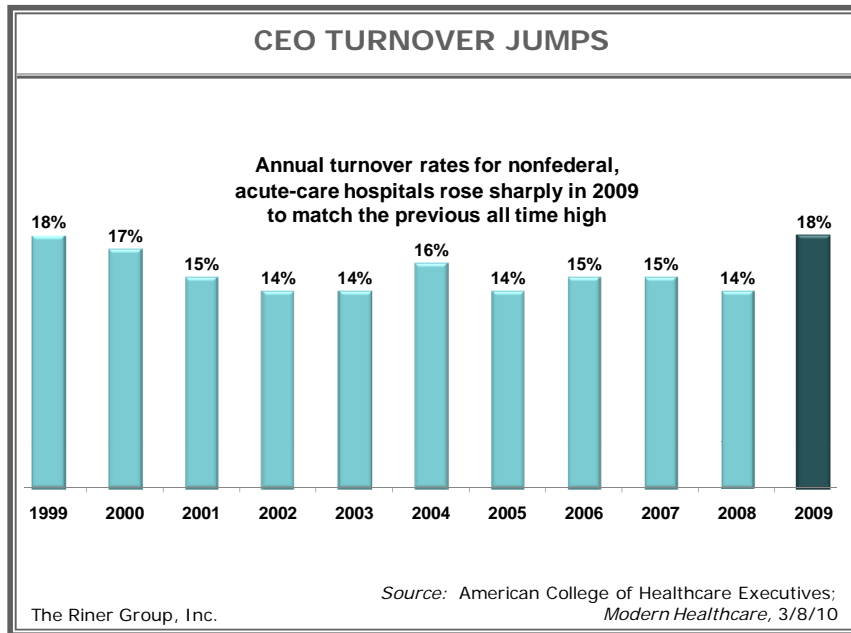




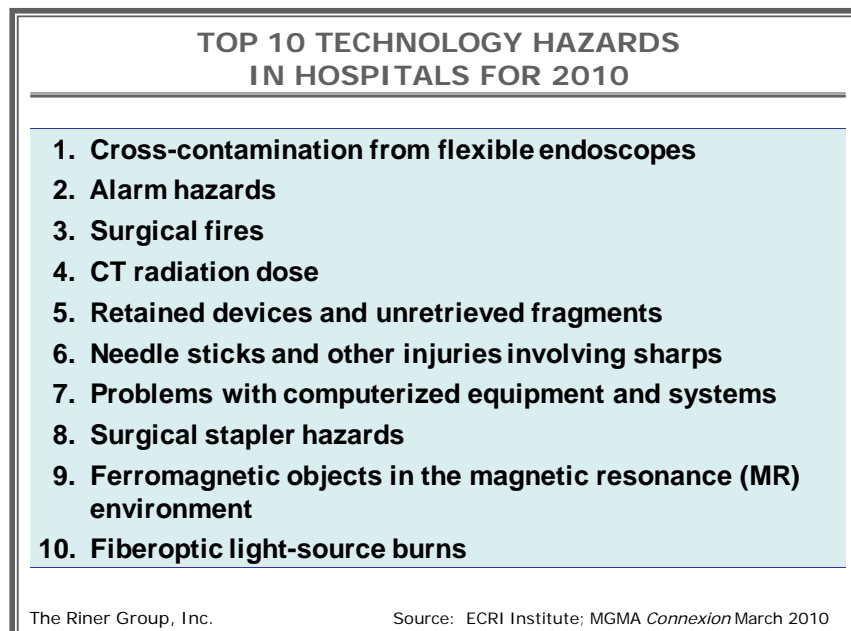
A CHALLENGE TO PHYSICIAN RELATIONSHIPS

Acute care hospitals saw a significant number of their CEOs leave organizations in 2009. 18% of hospitals experienced turnover in their top executive jobs, which is the highest rate since 1999. There are numerous reasons speculated as to why the turnover, not the least of which are the economy and the complexity of the environment in which hospital CEOs must perform. However, the high turnover rate challenges relationships between physicians/physician practices, (physicians are usually long-time residents of a community) and hospitals having turnover in the executive suite.



PATIENT SAFETY

Patient safety continues to be a major focus for patients entering into the acute care setting. This table shows the top ten technological hazards in hospitals for 2010.





HEALTH STATUS VARIES BY COUNTY

Physicians are often under the microscope for a host of practice variations frequently quoted as statistically significant. However, it should be noted that physicians cannot necessarily treat unemployment, violent crime, or dirty air, but these are many of the environmental factors that affect a person's health. According to a report released February 17, 2010 by the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, for the first time residents of rural counties are noted to be especially challenged by high poverty and a lack of access to primary care. The report grouped the healthiest county from each of the 50 states and each state's least health counties and found wide disparities. It is apparent that healthcare is only part of the process of being healthy.

COUNTIES' HEALTH VARIES WIDELY

Residents of the least-healthy counties in each state are much more likely to smoke, have preventable health conditions and die prematurely than people living in the healthiest counties in each state.

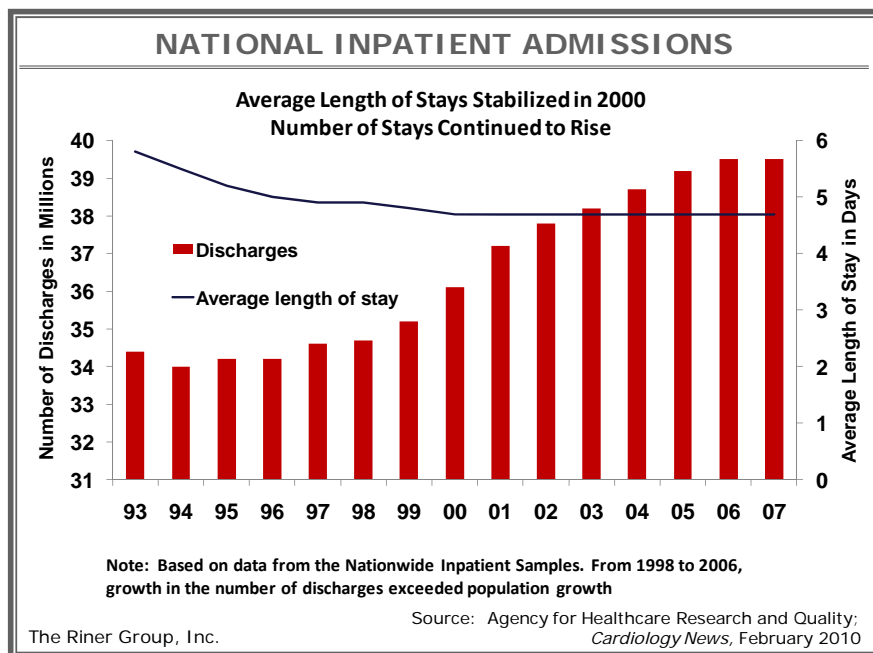
	Least healthy	Healthiest	Ratio
Premature death rate	12.368	4,904	2.5-1
Self-reported health status of fair or poor	20%	9.5%	2.1-1
Adults who smoke	26%	16%	1.6-1
Preventable hospital stays	95	61	1.6-1
Children living in poverty	30%	9%	3.5-1

Premature death rate is calculated as the years of potential life lost before the age of 75 per 100,000 people. Preventable hospital stays are calculated as per 1,000 Medicare beneficiaries

Source: "County Health Rankings," Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, February 2010; *American Medical News* 3/8/10

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NATIONAL DATA ON INPATIENT ADMISSIONS



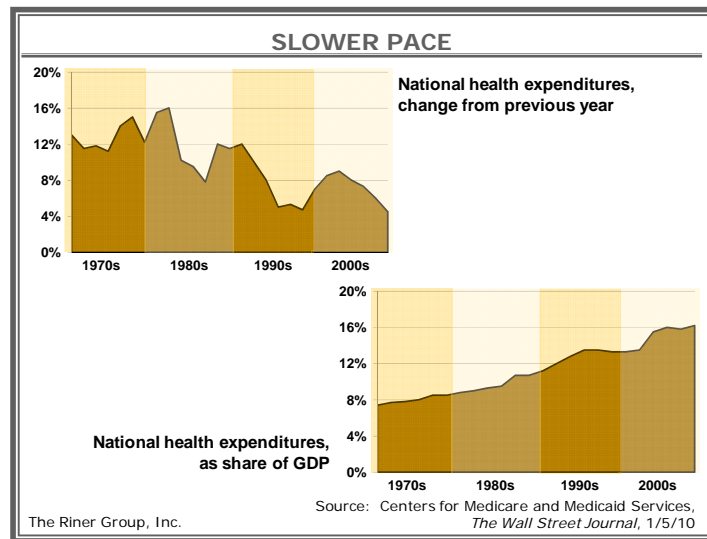
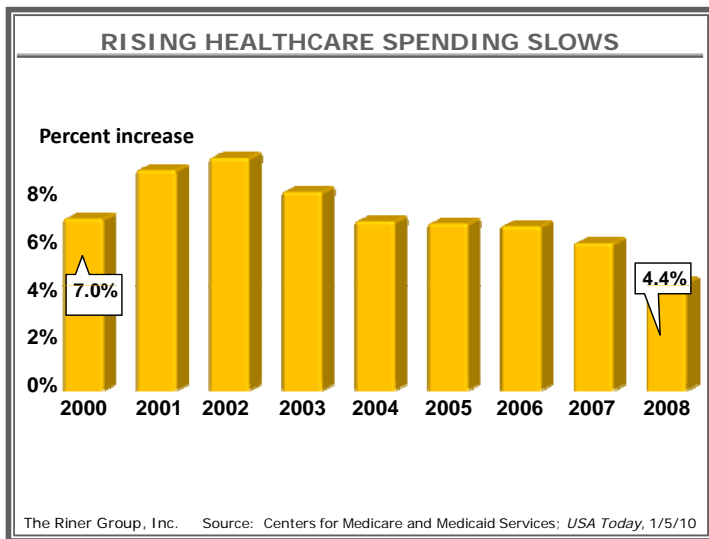


Volume 31 Issue 2

HEALTH OUTLAYS SLOW

April 2010

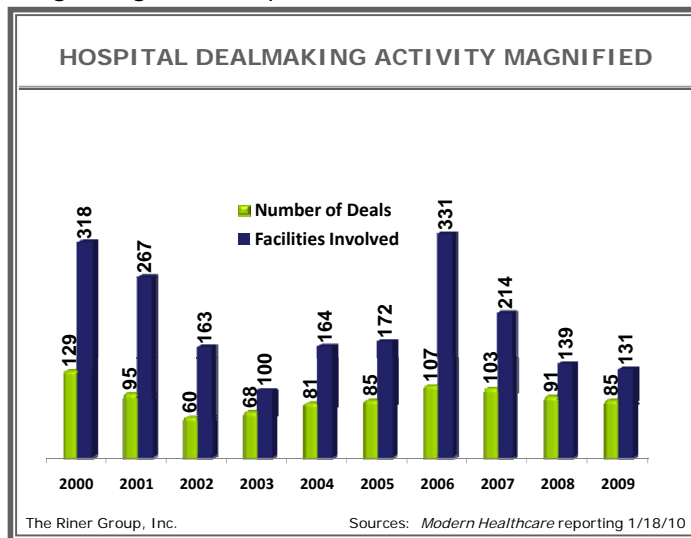
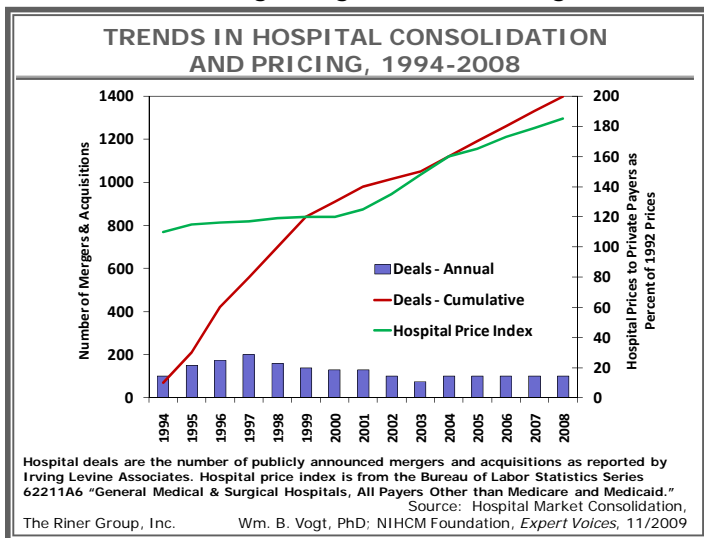
Healthcare spending rose 4.4% in 2008, the smallest increase in nearly 50 years as the recession caused consumers and employers to pare medical expenses. A report by the Federal Government's Centers for Medicare and Medicaid Services (CMS) found that healthcare spending rose \$2.3 trillion in 2008, or an average of \$7,681 per person and continued to outpace GDP growth.



HOSPITAL CONSOLIDATION AND PRICING

The inpatient hospital market in the U.S. underwent a significant amount of consolidation during the 1990s with over 900 mergers & acquisitions which left many cities dominated by two or three large hospital systems. By 2003 almost 90% of Americans in metropolitan areas faced a highly concentrated hospital market. A large amount of literature examines the effects of consolidation on hospital prices. The studies look at various methodologies, and the magnitude of the price increase varies by methodology and by characteristics of the markets under study, ranging from low-end estimates of 5% price hikes to increases of more than 50%.

The weight of the empirical evidence indicates that hospital prices generally increase following consolidation in the hospital market, sometimes by very significant amounts. While hospital mergers and acquisitions have tailed off in recent years, most signs point to an active 2010. In 2009, for the second straight year, there were very few hospital mergers & acquisitions. Grappling with the recession and tighter availability of capital, providers are now beginning to look once again at undertaking mergers & acquisitions.





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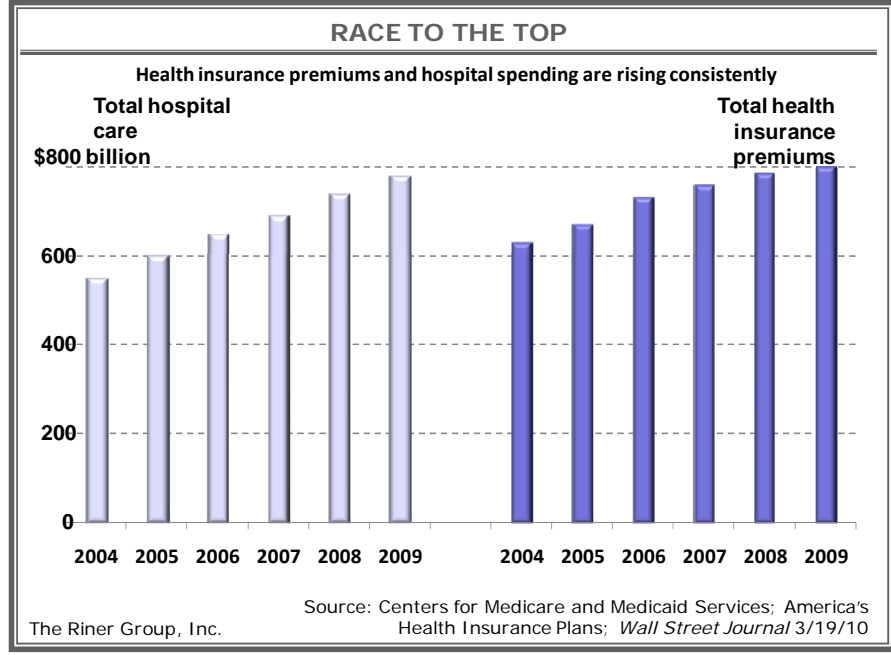


Volume 31 Issue 2

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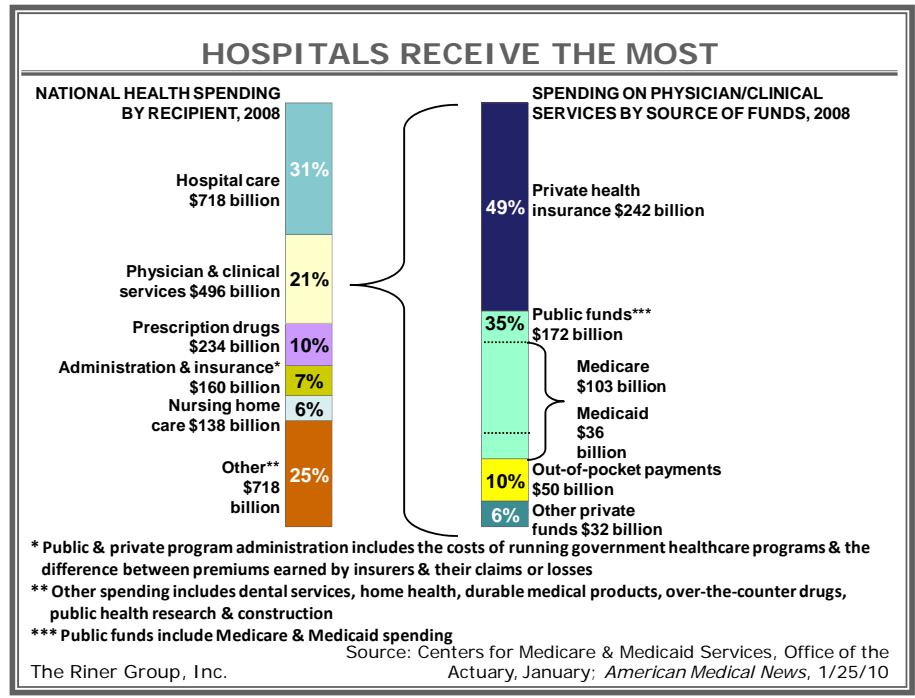
INSURERS VS. HOSPITALS ON RATES

Health insurers appear to be contesting hospitals' requests for higher reimbursement rates by threatening to drop many hospitals from their health plan networks. Fresh battles are occurring throughout the country. Hospitals are arguing that low Medicare rates and custom Medicaid mean that hospitals are having to seek higher rates. All of this is leading to higher premiums and higher pricing.



WHO GETS THE MOST? - FYI

Nearly a third of the nation's \$2.34 trillion in health spending in 2008 went to hospitals. Spending on physician care accounted for about a fifth of the total, with private health insurance being the single largest payer for doctors' services. However it should be noted that certain specialties are more heavily prone to rely on Medicare for payment (e.g., cardiology and orthopedics).





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Volume 31 Issue 2

April 2010

PERSONALIZED MEDICINE

The U.S. personalized medicine market is estimated at about \$232 billion today, and is projected to grow annually by 11% to more than \$450 billion in 2015, according to a report by PricewaterhouseCoopers. The mapping of the human genome and rapidly developing technology and diagnostic tests are contributing to the growth of personalized medicine.

Despite the recent recession and difficulties obtaining capital, the biotech industry in the U.S. raised a record \$55 billion in 2009 – through public and private partnerships and financing, according to Burrill & Co., a life science venture capital and banking firm in San Francisco. Major pharmaceutical companies are moving away from their traditional methods of developing pharmaceuticals.

The upside for our society is tremendous, and the impact will be pervasive throughout healthcare delivery. Despite predictions that our healthcare system is broken, it should be remembered that we are among the most innovative countries in the world for healthcare advances, and personalized medicine will be among those innovations.

GROWTH SPURT

Projected Growth in Personalized Medicine Market, 2009-15

Personalized medical care	44%
Remote patient monitoring/telemedicine	23%-92%
Medical retail	22%
Electronic health records	15%
Diagnostics/test	10%
Genomic products and services	10%
Health clubs	10%
Laboratory services	10%
Targeted therapeutics	9%
Nutrition/organics	7%
Nutrition wellness	7%
Disease management	6%
Alternative medicine	2%
OVERALL	11%

The Riner Group, Inc. Source: PricewaterhouseCoopers; Modern Healthcare 2/1/10

THE MOST FREQUENTLY BILLED MEDICARE DRGs

MOST FREQUENTLY BILLED MEDICARE DRGs

Most Frequently Billed Medicare DRGs <i>Ranked by 2008 Medicare patient discharges</i>	DRG code	Discharges	Cost (average) ¹	Margin (average)
Psychosis	885	434,549	\$9,377	(\$2,502)
Major joint replacement or reattachment of lower extremity ²	470	430,182	14,730	(4,460)
Septicemia without mechanical ventilation 96-plus hours ³	871	286,582	12,225	(1,709)
Rehabilitation ^{3,4}	945	278,406	15,088	727
Esophagitis, gastroenteritis and miscellaneous digestive disorders ²	392	271,635	4,716	(1,232)
Simple pneumonia and pleurisy ⁴	194	242,417	6,926	(1,569)
Heart failure and shock ³	291	226,119	9,875	(2,646)
Heart failure and shock ⁴	292	221,198	6,709	(1,321)
Kidney and urinary tract infections ²	690	213,164	5,108	(1,010)
Chest pain	313	206,861	3,757	(1,234)

¹Estimated

³With major complication or comorbidity

²Without major complication or comorbidity

⁴With complication or comorbidity

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Sources: Thomson Reuters/Modern Healthcare, 1/18/10



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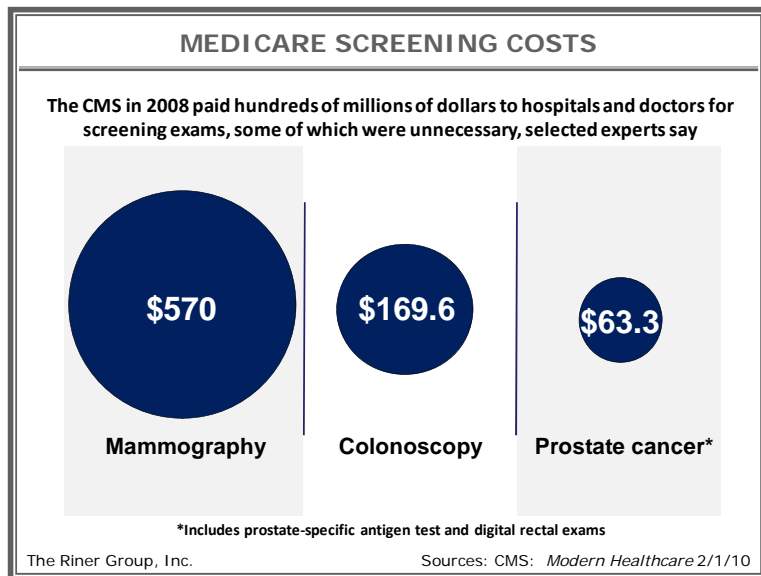


Volume 31 Issue 2

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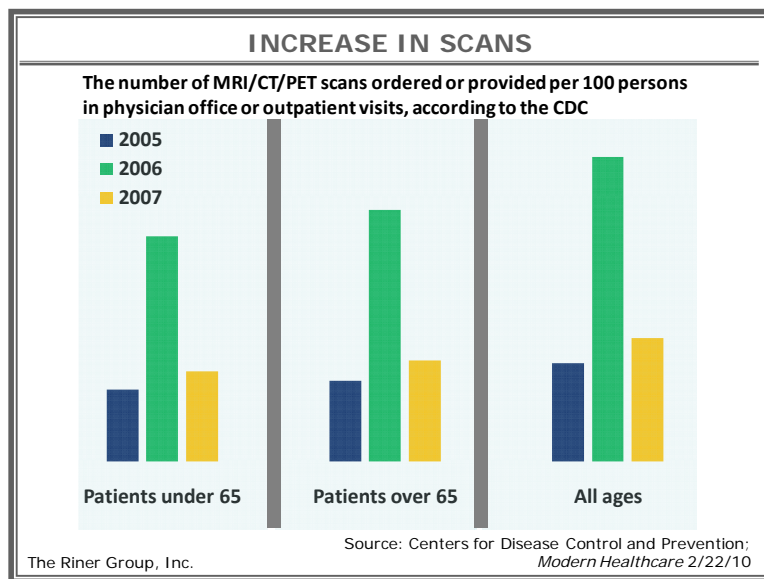
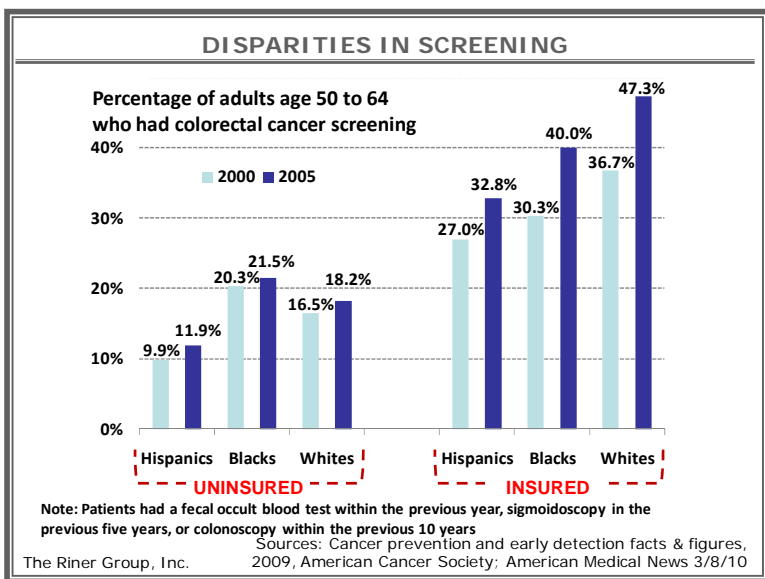
SCREENING PREVENTION AND COSTS

Considerable discussion is now occurring concerning the value of some of our healthcare screening techniques. In part this is driven by a perceived benefit to those that have normal outcomes on the screening. For example, while numerous medical tests are available, some are questioning how often they are necessary and who will pay for them. The entire screening issue has been labeled “the third rail of health policy,” according to Gilbert Welch, a professor of medicine at Dartmouth Medical School and author of a book on testing for cancer. The graph demonstrates some of the data behind these discussions, which will undoubtedly continue to unfold, especially with rising healthcare costs and readily available information in our age of transparency.



However, despite all of the debate about healthcare costs there remain disparities in certain screening activities. To no surprise, Americans without healthcare insurance are less likely to receive colorectal cancer screening than those with insurance. Among those with insurance, screening rates were better for whites than for blacks and Hispanics.

As federal lawmakers discuss ways to trim healthcare costs, they are wrestling with the fact that the amount of imaging being undertaken in our country has increased immensely. The rate of MRIs, PET and CT Scans in the U.S. tripled between 1996 and 2007. Some of this is a reflection of the fact that our current diagnostic capabilities are enhanced by virtue of these tests. Other studies would suggest that they are potentially being over-utilized in certain settings. This debate will also continue to rage over the course of the next several years.



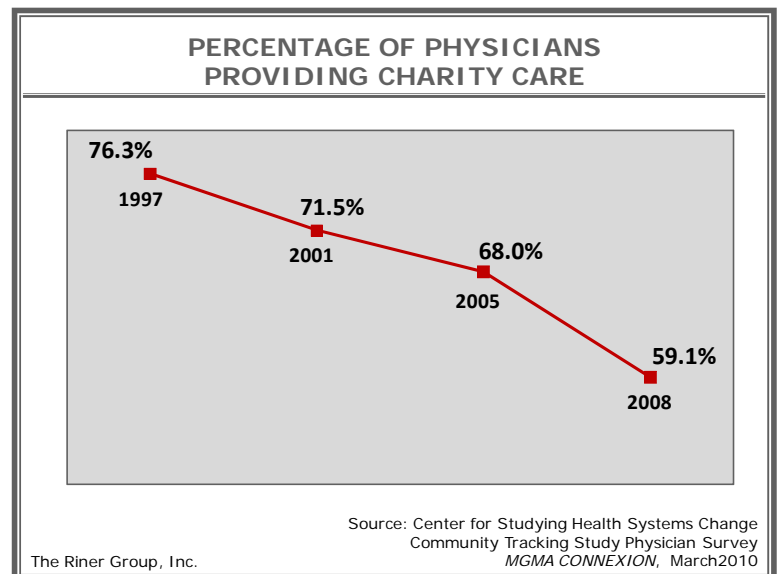


DID YOU KNOW?

- Online contact between physicians and patients is growing** – The recently released report by Manhattan Research, “Physicians in 2012: The Outlook on Health Information Technology,” found that 39% of physicians use email, secure messaging and instant messages to communicate with patients, up 14% from 2006. Dermatologists were the most likely users, followed by oncologists, neurologists, endocrinologists and infectious disease experts. Primary care physicians ranked sixth on the list.
- Medical Office Condos** – First emerged in the 1970s, but became more popular in the past decade in some areas of the country, such as Arizona, Florida and Nevada. Statistical evidence suggests that the value of these properties has gone down in our current real estate market, although not as much as some of the general office condos and other commercial real estate. According to data from CoStar Group, Inc. in Bethesda, MD, there were 13,710,448 square feet of medical office condo space, in 4,074 buildings, available for lease or sale across the country in the fourth quarter of 2008. The numbers went up to 15,952,799 square feet, in 4,550 buildings, in the fourth quarter of 2009, suggesting that there is much more space on the market available, which accounts for the price declines.
- Congenital Heart Disease/Adulthood** – Infants born with a congenital heart disease during 1990-1999, who then underwent care at a tertiary center had an 89% actuarial survival rate to age 18 or older, based on data of more than 3,800 patients at a data repository at a Catholic University in Leuven, Belgium. The rate was a significant improvement over an 85% survival to adulthood rate for infants with congenital heart disease born between 1980-1989 and managed at the same center, and an 82% survival rate to age 18 or older in infants born during 1970-1979. This information was presented by Philip Moons, PhD at the annual scientific sessions of the American Heart Association.
- Charity Care** –The graph demonstrates the results of the Health Tracking Study Physician Survey conducted by the Center for Studying Health System Change, a Washington DC based nonpartisan policy research organization. As shown in the graph, the percentage of physicians indicating they provide charity care has decreased from 76.3% in 1997 to 59.1% in 2008.

The Medical Group Management Association Cost Survey, 2009, based on 2008 data corroborates these findings. Today's economic environment of constrained insurance payments and static reimbursement from federal and state sources has definitely appeared to place increased demands on practices and is directly attributable to the decreasing amounts of charity care provided. Of note is the fact that other research has been following charity care and faith beliefs. Researchers were surprised by the discovery that physicians who consider themselves religious are not more likely to care for the poor than doctors with no religious affiliation.

Of the 1,144 physicians surveyed nationwide, 31% of the doctors who are “more religious” said they practiced medicine among the underserved. That's 4% lower than 35% of doctors who said they had no religious affiliation. This study was in the July/August 2009 Annals of Family Medicine.





DID YOU KNOW?

- **Heart Disease and Stroke Treatment Costs** – The projected estimated costs for cardiovascular disease (CVD) on stroke treatments in the U.S. will reach \$503.2 billion in 2010, which is a 5.8% increase over the previous year, according to the “Heart Disease Statistics-2010 Update” published in the December 17th issue of *Circulation*.
- **Online Visits** – Anthem Blue Cross and Blue Shield of Maine launched a *pilot program* to patients of physicians at two medical centers affiliated with Eastern Maine Healthcare Systems. Patients can communicate by email with their physicians about non-emergent issues in addition to scheduling appointments, checking on test results or requesting prescription refills. Watch for this trend to continue in other sections of the country.
- **Group Visits** – Group visits are usually with 8-12 patients and come in two forms: Shared Medical Appointments (SMAs) and Drop-In Group Medical Appointments (DIGMAs). From the physician’s perspective group visits provide numerous benefits.
 - ✓ Increase physician satisfaction by eliminating the repetition of one-on-one visits
 - ✓ Increase productivity because they involve multiple patients
 - ✓ Increase coordination of care, and
 - ✓ Improve patient education

Patients consistently report better disease-specific knowledge and satisfaction with their care in group visits. Additionally, the business case for SMAs is straight forward: patient and physician satisfaction improve and it’s not hard to maintain increased productivity. Billing is a key issue for this venture. At this time, no third-party payers distinguish between group and individual visits. The key is charting and documentation. Reimbursement is based on documentation, so physicians using this methodology will need to make sure that they accurately document all components of the visit. Other charges may be appropriate, such as the extended CPT Code 99354 for prolonged physician service and face-to-face patient contact beyond the first hour.

Source: *MGMA Connexion*-March 2010

- **Bad Grades For Medicare** – A new poll of practice managers finds Physician Quality Reporting Initiative (PQRI) report cards remain difficult to obtain and are of little value. According to research released February 17th by the Medical Group Management Association, Medicare’s PQRI program, now in its fourth reporting year, continues to frustrate physicians’ practices that are looking to access feedback reports from past years and use them to improve their patient care.

MGMA surveyed practices representing more than 11,000 physicians and found that fewer than half were able to access their PQRI feedback reports from the 2008 reporting year. Many remain skeptical that the government will be able to rectify the situation in a timely manner.



DID YOU KNOW?

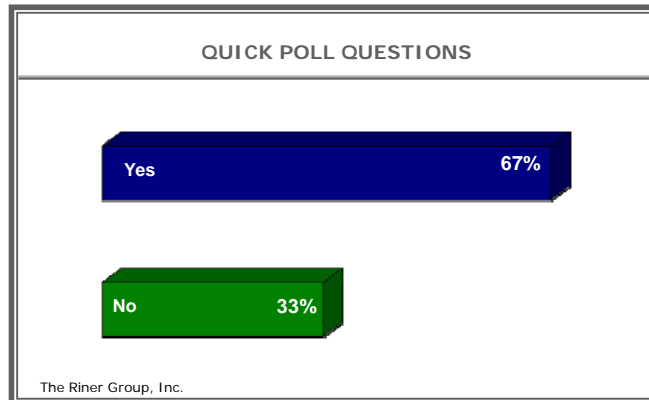
- **Decreasing Physician Work Hours** – According to a study in the Journal of the American Medical Association, doctors are steadily cutting their work hours over the past decade from about 55 to 51 hours per week. The report showed that the decrease in hours was linked directly to falloff in fees paid to physicians. Charges declined 25% after inflation from 1995-2006. Notably, where fees were lowest, so too were the hours worked weekly. The researchers estimated that a 5.7% decrease in hours among a workforce of 630,000 doctors is equivalent to the loss of nearly 36,000 doctors – just at a time when many are predicting there will be a workforce shortage among physicians.
- **Let the Lobbying Begin** – Lobbying appears recession proof. 2009 appeared to be a year of riches unlike any other, according to the Center for Responsive Politics. At nearly \$266.8 million, the pharmaceutical and health products industry federal lobbying expenditures not only outpaced all other business industries in special interest areas in 2009, but stand as the greatest amount ever spent on a lobbying efforts by a single industry for one year. Rounding out the top 10: computers/internet companies (\$118.9 million); general manufacturing and distributing (\$113.4 million); hospitals and nursing homes (\$108.4 million); television, movies, and music (\$107.3 million); and education (\$98.6 million).
- **CT Angiography (CTA)** – Despite recent concerns over the frequency of use and possible associated radiation, CTA is rapidly emerging as the most cost-effective imaging technique to exclude coronary artery syndrome in the Emergency Department (ED). The overall diagnostic accuracy of CTA is essentially equivalent to that of SPECT myocardial perfusion imaging, its main competition. Chest pain accounts for more than 6 million ED visits annually, resulting in 1.24 million admissions for unstable angina/non-ST-elevation MI (STEMI) and another 330,000 for STEMI. Emergency physicians are eager for new ways to rapidly and reliably rule out coronary syndrome – and CTA potentially may fill that bill. In a recent 16-center CT-STAT trial, which is now going to press, 701 low-risk patients with chest pain and a nondiagnostic ECG in the ED were randomized to CTA or the hospital's standard protocol, with serial biomarkers along with SPECT myocardial perfusion imaging. The time to diagnosis averaged 6.3 hours in the group who received the standard work-up compared to 2.9 hours with CTA, a 53% reduction. Median costs to obtain a diagnosis were \$3,158 with standard protocol and \$2,137 with CTA, a 38% reduction.
- **Home Builders and Real Estate Developments for Boomers** – The recent financial crisis and alterations in the real estate world have had impact on how developers are approaching the baby boomers. A recent study by MetLife and National Association of Home Builders (NAHB) called "Housing for the 55+Market: Trends and Insights on Boomers and Beyond" shows that more than 55+ homeowners are increasingly eager to buy into "age-restricted" communities where the emphasis is not so much on square footage or granite countertops, but on the active lifestyle that Boomers indicate they want. In comparison between 55+ homeowners in private residence vs. age-restricted active adult communities, customer satisfaction levels were higher for the latter group. The data also showed that more Boomers are looking for smaller, less expensive homes, and want to live in communities close to where they work (Boomers are reluctant to retire at age 65, according to the study). Additionally, the percentage of study participants who opted for smaller homes closer to their place of employment rose from 11.4% in 2001 to 16.6% in 2007.



OUR QUICK POLL RESULTS

The following question was posted on the Riner Group Website for the months January-March 2009.

" Should Hospitals and Physicians use Social Networking sites to engage their communities?"



Perspective: Social networking sites such as YouTube, Facebook and Twitter currently boast nearly 350 million users, and are accessed by patients to network with others who are battling the same diseases or to find clinical information, and by clinicians to share information and learn from one another. However, most health systems remain reluctant to enter the social networking sphere. Although social networking sites offer an opportunity to interact with patients, hospitals often avoid them over privacy and confidentiality concerns. In addition hospitals are concerned over control of content management. If hospitals adhere to HIPAA guidelines, social networking is not different from traditional forms of media.

Hospitals looking to venture into social networking may wish to start with blogs. The advantage of a blog over a social network site is the hospital has sole control over the content. It also provides an opportunity for a hospital to gauge their ability to provide the support and resources necessary to manage the blog and potentially other social networking sites.

Hospitals that are comfortable launching into social networking can utilize various sites as an extension of their existing marketing and outreach programs. For example, educational videos that are currently on the hospital's website can be put on YouTube. Twitter can be utilized to interact with patients and answer questions as appropriate, and news, podcasts, patient questions and commentaries can be posted on a Facebook page.

The ROI on social networking can be measured by the number of visitors or the positive versus negative comments, but there is also a human component to social networking that cannot be measured in numbers or financial terms. The cost of entry is very low and basically only includes an employee's time needed to set up the account. The ongoing expense is also relatively low and consists of employee time and IT support. Once a hospital makes the decision to launch into social networking it is important it devotes the resources necessary to keep the content current and communication flowing.

Social networking can provide hospitals an opportunity to interact with patients in ways they have not in the past. If managed correctly it can be an invaluable tool to reach new patients and enhance relationships with existing patients.

Physicians in their practices are confronted with many of the same concerns and opportunities as apply to hospitals. There are a plethora of existing and evolving social networking sites. An additional challenge to physicians is the time consuming aspect of visiting and updating the numerous sites, a luxury most practitioners do not have. However, watch the social networking trend grow in all healthcare settings. **Page 10**



SPEAKING ENGAGEMENTS

Dr. Riner and his colleagues frequently speak at events across the United States. The topics offer interesting perspectives on healthcare issues for you to share with your colleagues as you strategize for the future of your practice or healthcare organizations.

Contact us at 800-965-8485 to discuss a speaking engagement with us on a topic pertinent to your organization.

UP TO DATE REFERENCES AVAILABLE ON THE RINER GROUP WEBSITE – www.rinergroup.com

For the convenience of our clients we have posted numerous RSS feeds to help you access up-to-date and accurate information for our ever changing healthcare industry. We have put *at your fingertips* quick access to articles on healthcare issues in – Business – Clinical Cardiology – Medical News – Physician Compensation & Recruitment – Finance – IT – and Blogs. By clicking on Resources/News Flashes on our homepage, you can quickly and easily find your area of interest and peruse a number of articles on the subject. If you don't find what you're looking for, contact us and we'll do our best to accommodate your needs.

ANOTHER NEW RINER GROUP PUBLICATION

Continuing our efforts to keep our clients and readers informed on what's happening in healthcare we recently published an article in *Cardiovascular Business* – "Is Specialty Medicine Applicable to a 'Concierge' Practice Model?" You can find this article and many more posted on our website by clicking on Resources/Articles from our homepage.

OUR FOCUS

With over 30 years of business experience in healthcare, we have worked with physician practices, hospitals, health systems, academic medical centers and healthcare businesses throughout the United States with a focus on strategy, new business development and performance improvement. We specialize in integrating the business and clinical aspects of healthcare.

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