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HEALTHCARE • MANAGEMENT CONSULTING

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Mediscene Newsletter

Volume 29 Issue 3

December 2008

Season's Greetings

WISHING YOU A HAPPY & PEACEFUL HOLIDAY SEASON!

The staff of The Riner Group

Mediscene Newsletter

Volume 29 Issue 3 December 2008

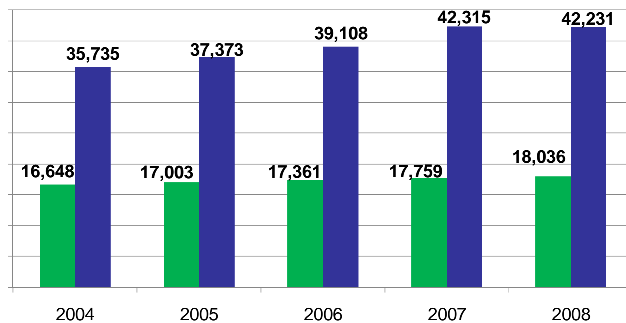
GOOD NEWS, BAD NEWS

Enrollment at the nation's medical schools is up. First year enrollment at the nation's medical schools in 2008 increased nearly 2% over 2007 to more than 18,000 students, the highest enrollment in history. What offsets this promising statistic is a 3% decline in the number of first time applicants in 2008.

Data from the Association of American Medical Colleges suggests that 27% of all U.S. medical residents and fellows in 2007-2008 academic year were international graduates. Nearly 24% of all practicing physicians in the U.S. during 2006 were internationally recruited doctors, according to the American Medical Association.

FEEDING THE PIPELINE

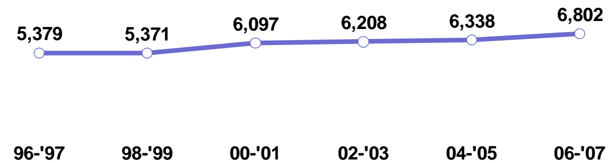
After years of growth, the number of applicants to U.S. medical schools dipped slightly in 2008



The Riner Group, Inc. Source: Association of American Medical Colleges; *Modern Healthcare*, 10/27/08

OF FOREIGN ORIGIN

The number of international medical graduates entering U.S. graduate medical education has increased 27% over the past decade



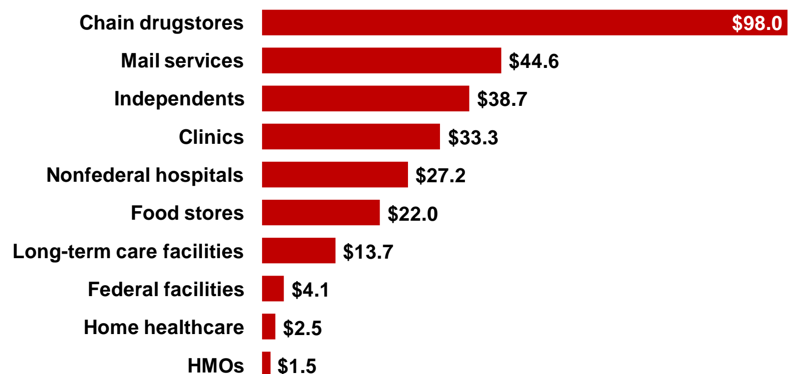
The Riner Group, Inc. Source: Association of American Medical Colleges; *Modern Healthcare 9/29/08*

NEW PAYMENT POLICY FOR E-RX COMPLIANCE

Federal officials are urging physicians to begin electronic prescribing as soon as possible now that Congress has authorized bonus payments for the successful use of the technology. Under the recently enacted Medicare Improvements for Patients and Providers Act (MIPPA) – the same law that eliminated the 10.6% Medicare physician pay cut – Congress also outlined plans to ramp up e-prescribing next year.

Beginning in 2012, eligible physicians who do not e-prescribe will see their total allowed Medicare charges cut by 1% with the amount increasing to 2% by 2014, according to the provisions of H.R. 6331. Professional societies are urging physicians to adopt electronic prescribing. This graph shows the top 10 areas for prescription drug distribution in the U.S. in 2007.

DRUG DISTRIBUTION IN 2007



The Riner Group, Inc. Source: IMS health; *Cardiology News, 9/2008*

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MOST FREQUENTLY BILLED MEDICARE DRGs

Ranked by 2006 Medicare Patient Discharges

Rank/DRG name	DRG code	Discharges	Cost (average	Reimbursement (average)	Margin (average)
1 Heart failure and shock	127	673,596	$6,709	$5,543	($1,166)
2 Simple pneumonia & pleurisy[1]	89	523,198	6,763	5,357	(1,405)
3 Major joint replacement or reattachment of lower extremity	544	451,086	13,806	10,258	(3,548)
4 Psychosis	430	450,994	8,479	6,256	(2,224)
5 Chronic obstructive pulmonary disease	88	414,709	5,961	4,649	(1,312)
6 Esophagitis, gastroenteritis and miscellaneous digestive disorders[1]	182	352,575	5,465	4,390	(1,075)
7 Septicemia[2]	416	326,943	11,058	9,930	(1,128)
8 Rehabilitation	462	293,888	12,875	14,501	1,626
9 Intracranial hemorrahage or cerebal infarction	14	293,320	7,994	7,245	(749)
10 Gastrointestinal hemorrhage[3]	174	259,877	6,855	5,322	(1,534)
11 Kidney and urinary tract infections[1]	320	246,059	5,641	4,510	(1,131)
12 Renal failure	316	241,195	7,817	7,158	(658)
13 Chest pain	143	233,256	3,454	2,592	(861)
14 Nutritional and miscellaneous metabolic disorders[1]	296	227,710	5,396	4,377	(1,019)
15 Cardiac arrhythmia and conduction disorders[3]	138	217,970	5,462	4,226	(1,235)
16 Percutaneous cardiovascular procedures with drug-eluting stent without major cardiovascular diagnosis	558	184,632	12,201	12,098	(102)
17 Respiratory infections & inflammations[1]	79	164,703	10,499	9,147	(1,352)
18 Respiratory system diagnosis with ventilator support	475	144,091	22,076	25,577	3,502
19 Circulatory disorders with AMI[4] and major complications	121	138,086	9,535	8,257	(1,279)
20 Cellulitis[2]	277	131,889	5,933	4,724	(1,209)

Note: Dollar figures rounded

[1]With patients older than 17 with complication or comorbidity

[2]With/patients older than 17

[3]With complication or comorbidity

[4]Acute myocardial infarction

Source: Thomson Reuters; *Modern Healthcare 7/28/08*

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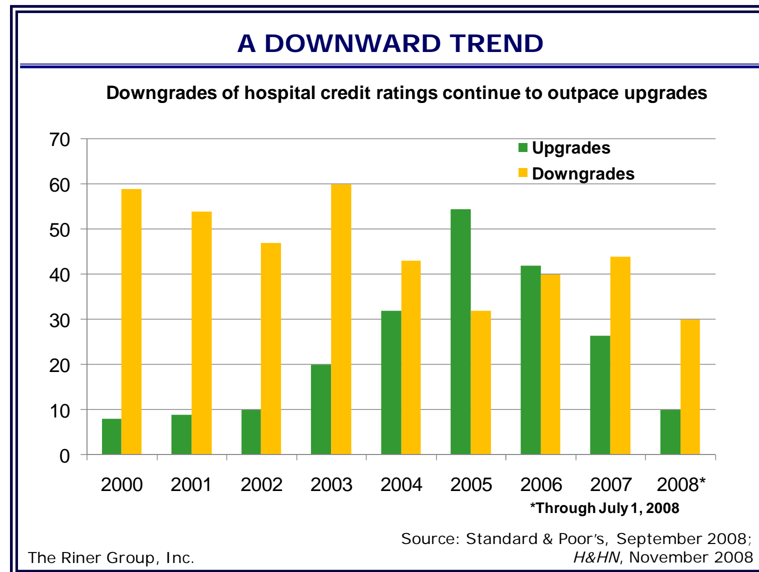
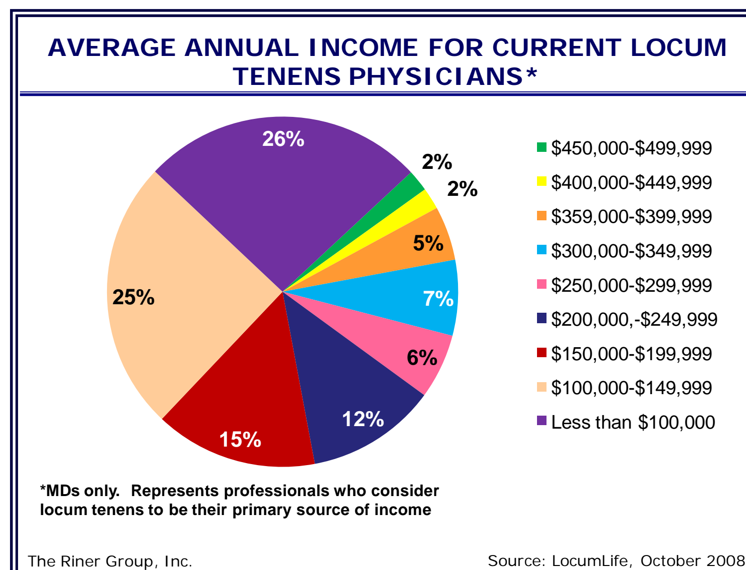
DOWNWARD TREND

The economy is definitely taking a toll on hospital's credit ratings as downgrades outpace upgrades in credit ratings. Decreasing volumes may be a reflection of the significant economic downturn experience across the country and internationally. Many hospital advocates suggest improved physician relationships as a significant means of shoring up finances – an area where The Riner Group is heavily engaged and focusing upon with our national clientele.



LOCUM TENENS

The freedom to select where and when to practice is what drives many physicians to become locum tenens professionals. MDs providing locum tenens services as their primary source of income earned $175,000 a year on average. Over a third reported making $200,000 or more in the past 12 months with 17% topping the $300,000 mark. Just over half took home less than $150,000 per year. In addition, 71% of current locum tenens physicians said they used temporary opportunities to supplement their income for a permanent practice or other regular position. These data come from a recent survey conducted by *LocumLife* in October 2008.



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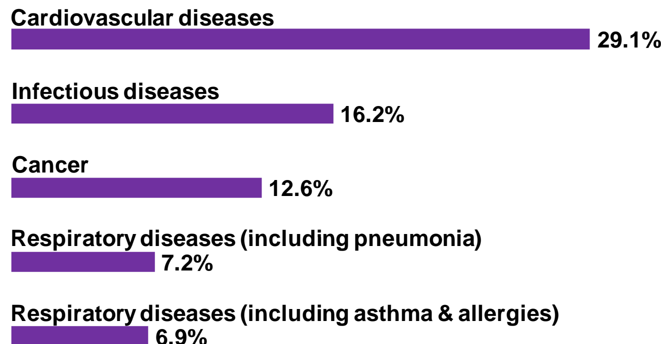
HEART PROBLEMS STILL RULE

Heart ailments, infectious diseases and cancer remain the leading causes of death in the world, the United Nation's health agency recently reported. Heart attacks and related cardiovascular problems are the top killers – especially among women – and claim 29% of people who die each year, the World Health Organization said in a report on the global burden of disease. The report is based on death registration data from 112 countries and estimates where reporting is incomplete. The figures are from 2004, the most recent year for which records are available on a wide scale. The rankings, interestingly, are unchanged since 1990. It is noted that deaths from cancer are projected to rise globally to the number one position in the future.

WORLD'S TOP KILLERS



Sources: WHO: The Global Burden of Disease (2204 Update); *USA Today*, 10/28/08
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PCI WITHOUT SURGERY ON SITE – ONGOING SAGA

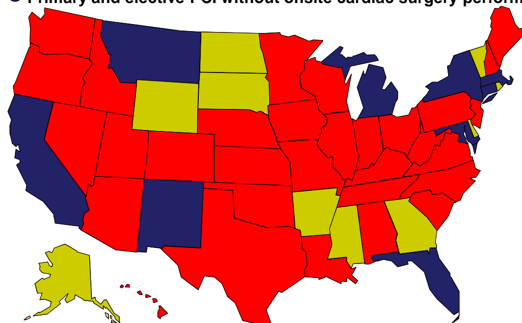
Elective PCI is currently a Class III indication, which means there is "evidence and/or agreement that it is not useful or effective, and may be harmful." The ACC/AHA/SCAI guidelines state that elective PCI should not be performed at institutions that do not provide onsite cardiac surgery. An update to the guidelines in 2005, however, stated that the recommendations "may be subject to revision as clinical data and experience increase" due to the fact that several centers without onsite surgical backup have reported satisfactory results.

The fact remains that because of the sophistication of interventionalists today and the improvement in technology, surgery during elective PCI is rarely required. The issue has not necessarily become lack of surgical backup but rather the entire issue has become a surrogate for "low volume." In general sites without surgical backup have low volumes, whereas sites with surgical backup have higher volumes. There is currently a debate as to the number of cases that need to be performed to maintain proficiency of the operator as well as the ancillary support team. The current guidelines state to maintain proficiency a cath lab needs to perform a minimum of 100 PCIs annually, of which 36 should be primary PCI (primary cardiac interventions).

LOW-VOLUME CATH LABS WITHOUT SURGICAL BACKUP HERE TO STAY

States that Pay for PCI WITHOUT Surgical Backup

No PCI without onsite cardiac surgery
Primary PCI without onsite cardiac surgery performed
Primary and elective PCI without onsite cardiac surgery performed



Sources: The majority of U.S. states cover PCI without onsite cardiac surgery support; Source: Carl L. Tommaso, MD, Rush North Shore Medical Center, Skokie, IL; *Cardiovascular Business*, 10/2008
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Several trials continue to clarify this issue. Despite the controversy over the specific types of clinical trials, evidence exists that suggests that PCIs can be performed successfully in institutions without cardiac surgical backup. This matter will continue to be debated and will clarify itself as more data becomes available.

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PHYSICIANS TALLY THEIR ECONOMIC VALUE TO THEIR COMMUNITIES

Around the country, physicians are letting their communities know that their practices not only keep individuals healthy, they also keep economies healthy. Even in tough economic times healthcare can be considered a growth area and an "economic good." These tables relay some of the economic impact provided in recent studies.

THE IMPACT IN KANSAS CITY

The Metropolitan Medical Society of Greater Kansas City conducted a study on the economic impact of physician practices

Typical Practice
4 Physicians
15 Full time staff
2 Part-time staff

Overall
4,000 ft, 500 PT physicians
21,000 ft, 3,200 PT employees
$102,537 average annual professional compensation
$2.7 billion payroll for practices
$191 million annual capital investment
$1 billion operating expenses
$202 million paid in taxes

Sources: "2008 Metro Medical Economic Footprint Study," Metropolitan Medical Society of Grater Kansas City, October. Data based on FY2007 & gathered from 4,428 MDs representing 356 local practices & hospitals; *American Medical News*, 11/10/08

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THE POWER OF FAMILY PRACTICE

The American Academy of Family Physicians conducted a nationwide study on the economic impact of family practices. Here is a sampling from each region of the country.

	Economic Impact per physician	Collective impact per year
New York	$1.0 million	$2.9 billion
Florida	$941,000	$3.5 billion
Ohio	$923,000	$2.4 billion
Michigan	$907,000	$1.8 billion
Mississippi	$1.3 million	$819 million
Colorado	$892,000	$1.1 billion
Idaho	$812,000	$350 million
Texas	$1.1 million	$5.4 billion

Sources: "Economic Impact of Family Physicians in Your State," Robert Graham Center for Policy Studies, presented at the North American Primary Care Research Group Annual Meeting, October 2006; Data on office-based family physicians per state from the area resource file database for 2003; physician/staff value data from 2002 Medical Group Management Assn. survey based on 2001 data; *American Medical News*, 11/10/08

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GOOD FOR THE BOTTOM LINE IN GEORGIA

The Association of George commissioned its own physician economic impact study. Results were released 10/28/08. Among the findings:

- **18,500** physicians
- **180,000** jobs they support
- **$10 billion** physician office annual payroll
- **$20 billion** physician-generated economic activity
- **$1.2 billion** contribution to state government revenues
- **$1.5 billion** contribution to local government revenues
- **270,000** estimated physician-support jobs by 2020
- **$17.8 billion** estimated physician-generated payroll by 2020
- **$32 billion** estimated physician generated economic activity by 2020
- **293,000** jobs in 2020 if predicted 2,500-physician shortage is alleviated
- **$19.3 billion** payroll in 2020 if predicted physician shortage is alleviated
- **$34.50 billion** economic activity in 2020 if predicted physician shortage is alleviated

Sources: "The Estimated Economic Impact of Private Practice Physicians' Offices in Georgia," Carl Vinson; Institute of Government at the U. of Georgia, commissioned by the Medical Assn. Of Georgia; *American Medical News*, 11/10/08

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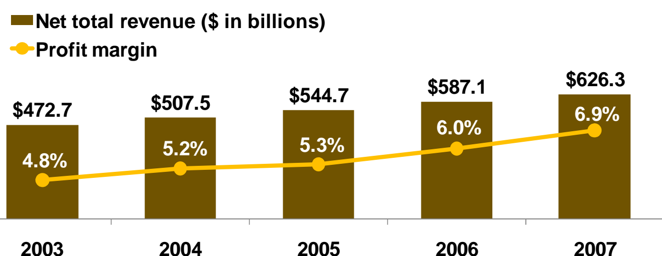
FINANCES

The second half of 2008 certainly looks different than the first half of 2008 for hospitals and health systems. Current data darkened the optimism that surrounded 2007. 2007 was a banner year for revenue and strong profit margins. However, as stated previously, many of the hospitals are seeing downgrades in their bond status and are struggling financially. Additionally, charity care and bad debt costs are expected to rise

A BANNER YEAR

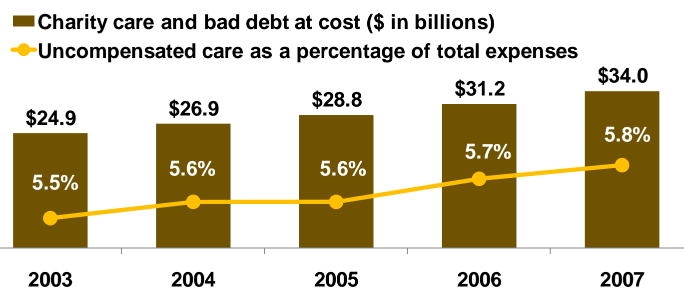
After record revenue and strong profit margins in 2007, community hospital results may take a hit this year and next



The Riner Group, Inc. Source: *AHA Hospital Statistics 2009; Modern Healthcare 11/17/08*

UNCOMPENSATED CARE

Charity care and bad debt costs are expected to rise in 2008 and 2009 among community hospitals



The Riner Group, Inc. Source: *AHA Hospital Statistics 2009; Modern Healthcare 7/2/08*

DID YOU KNOW?

- U.S. community hospitals enjoyed record profits in 2007, posting $43 billion more in revenue than expenses and creating the largest single-year jump in profit margins in at least 15 years, according to figures released by the American Hospital Association in its *AHA Hospital Statistics 2009 Edition*.

On the other hand, for the physician medical community, whose profession has faced the threat of Medicare payment cuts for at least 5 years, there was welcomed news that Medicare finalized a 1.1% pay raise, reversing a 10.6% cut that was to have taken effect this year. Starting in January 2009, a 1.1% across the board increase will replace an additional cut, roughly 5%, that would have gone into effect if lawmakers had not acted, the Centers for Medicare and Medicaid Services said in the final payroll issued in October 30, 2008. The final rule validated requirements set by the Medicare Improvement for Patients and Providers Act of 2008 (MIPPA) which halted a 6% pay cut scheduled for July 1, providing doctors with a 0.5% payment bump for the remainder of 2008. The 1.1% increase begins January 1, 2009.

In an effort to reduce medication errors and healthcare costs the rule also establishes a new program that offers an incentive payment of 2% to eligible providers that adopt and use qualified e-prescribing systems. Additionally, physicians who successfully support measures under the PQRI, another incentive program, can earn an additional 2% bonus. Coupled with a 1.1% overall base increase physicians are receiving in 2009, physicians could achieve up to a 5.1% increase next year in Medicare payments.

This is slightly encouraging considering the fact that for the last 10 years reimbursement for physicians has been flat. However, not all specialties will see the increase. Cardiologists are one group that may be impacted negatively. Even if cardiologists adopted e-prescribing and complied with PQRI and were thus eligible for a 4% bonus in addition to the 1.1% payment update, their increase might only be 1.3% due to the fact that most cardiology payments will actually go down 2% because of the relative value unit re-pricing by Medicare next year.

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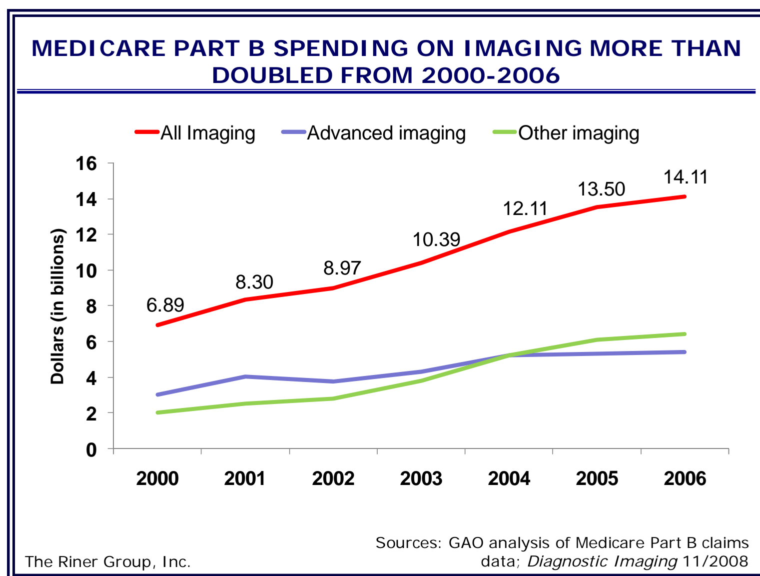
DID YOU KNOW?

• Consumers saw hospital prices rise 0.5% in October 2008. According to seasonally adjusted figures from the Bureau of Labor Statistics' consumer Price Index, the price of hospital services climbed 6.5% during the 12 months that ended in October compared with 7.7% for the prior year.

Physician-office prices increased only slightly, by 0.1% last month compared with 0.5% in October 2008 and 0.5% in September. For the year that ended in October, physician-office prices rose only 2.7%. For the same 1-2 month period a year ago, the physician CPI increased by 4.3%.

• Prior authorization takes command – creates havoc. Medical practice is becoming more imaging-focused. This is the result of technology and advances in medicine. However, in July of 2008 a study by the Government Accountability Office found that Medicare Part B spending on diagnostic imaging had more than doubled, to $14.1 billion, from 2000 to 2006.

High-tech MRI, CT, PET and Nuclear Cardiology were the biggest contributors to that growth (a follow up report from GAO found that Medicare costs then fell $1.3 billion in 2007 because of rate cuts ordered by the Deficit Reduction Act in 2005). Commercial insurers are seeing the same pattern. Imaging costs are increasing from 15% to 25% per year. In an attempt to stem the rising costs they are instituting prior authorization. As of mid September about 109 million privately insured Americans were subject to prior authorization for routine imaging, mainly for CT MRI, PET and Nuclear Cardiology. Insurers serving 55% to 65% of the commercial healthcare market now require referring physicians to check with them before ordering high-tech imaging – a fact that is creating havoc within medical practices and replicating the onerous activities of managed care in the late 1980s and 1990s. Though imaging related prior authorization has been in use for at least 15 years, most insurers have only recently adopted the strategy. Physicians complain that the prior authorization is disruptive, impeding efficient and effective patient care, and is frequently impeded by interaction with individuals who are not knowledgeable of the disease process and/or reasons for the decision making. On the other hand, professional societies are being challenged to develop specific criteria for the ordering of imaging modalities. Watch this process continue to play out in a large way over the course of the next 12-18 months.



• The promise of information technology is that it will improve quality and safety and give clinicians more time to spend on direct patient care. Of note, however, is the fact that a recent study found that nurses override barcode medication systems for 4.2% of all charted patients and 10.3% of medications charted. They did so because the information systems didn't work appropriately. Cumbersome technology is viewed by the clinical community as an impediment not an asset.

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DID YOU KNOW?

• Recruitment – As in past years, residents coming out of medical training programs have been heavily recruited. 94% of final year medical residents surveyed by Merritt Hawkins & Associates in their *2008 Survey of Final Year Medical Residents* (290 respondents, 36% in primary care and the rest in surgical and diagnostic specialties with 20 specialties represented) said they had been contacted by recruiters at least 11 times during the course of their training. 80% said they had been contacted by recruiters 26 times or more and 40% said they had been contacted at least 51 times. More than 90% received at least 10 job solicitations during training, and 80% received two dozen or more solicitations.

• World Population Growth, 2008-2050 – *World Population Data Sheet* estimates world population at 6.71 billion as of mid-2008, growing to 8.00 billion in 2025, and 9.35 billion in 2050. But this masks huge variations in national and regional growth by 2050, e.g., Northern Europe +19% vs. Eastern Europe -22%; Middle Africa +151% vs. Southern Africa +12%; U.S. +44% and India +53% vs. Russian -22% and Japan -25%.

• Estimates suggest 770,000 new cases of myocardial infarction with an additional 175,000 silent MIs are expected in 2008. By 50 years of age, most U.S. adults have significant coronary atherosclerosis. This atherosclerotic process remains silent for decades until it finally presents with plaque rupture and thrombosis. This analysis results from a 26-year Framingham Heart Study follow-up data which also showed that 50% of individuals who develop coronary artery disease are identified using total cholesterol levels alone.

• Spending on Medicaid is expected to increase 7.3% from 2007 to 2008 and continue to climb over the next decade, topping $339 billion this year and nearly doubling to $674 billion by 2017.

• Better handwashing is one of the most effective ways of preventing the 2 million hospital-acquired infections that occur each year. However, research shows that caregivers only follow proper hand hygiene protocols about 40% of the time. If improved hand washing eliminated just 10% of these infections we would save 10,000 lives and $3 billion each year.

• In a recent survey by the *Journal of the American Medical Association (*JAMA) only 2% of fourth-year residents plan to work in primary care internal medicine. The drop of primary care physicians has been linked to an increase in poor health outcomes. 42% of family practice physicians were filled in the recent year, garnering salaries averaging around $185,740. This is in contrast to orthopedics, which filled 93.8% of its residency and radiology at 88.7%. Salaries for orthopedists and radiologists averaged approximately $400,000 annually.

• The American Hospital Association tracks the build-out of freestanding ERs. In 2006, the most recent year for which data is available, roughly 4.3% of AHA-member hospitals responding to a survey reported that they were operating freestanding ERs. The number of freestanding ERs grew to 179 in 2006, up 20% from the prior year. This definitely represents a growing trend along with the development of Urgent Care Centers. There are an estimated 8,000 to 10,000 Urgent Care Centers in the U.S. and over 20,000 physicians, physician assistants and nurse practitioners practicing in this arena. Urgent Care Centers are usually located in communities with populations of 20,000 or more. The facilities are requesting longer term, full-time coverage as well as weekend moonlighting services. Urgent Care physicians of all career stages can expect to earn from $65 per hour to $90 per hour according to industry experts.

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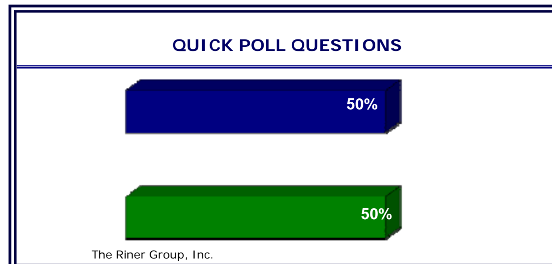
OUR QUICK POLL RESULTS

December 2008

The following question was posted on the Riner Group Website for the month of July 2008.

" Do you think consumers are capable of judging the quality of hospitals or the healthcare service they seek?"



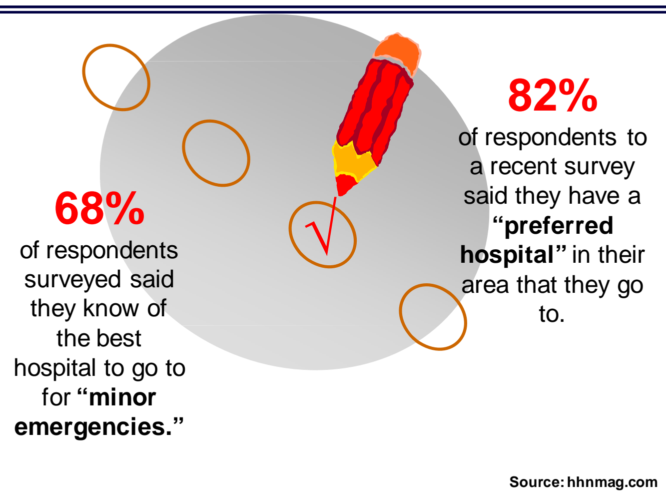
Perspective: It would appear consumers approach healthcare in much the same way they approach other services – they look for quality *as measured by convenience* and are loyal to places where they have had *positive experiences*. Building a loyal customer base is a focus for many hospitals at this time, at a minimum to maintain patient volume. The majority of healthcare consumers believe they know the best hospital to go to for most medical treatments, however the level of confidence varies. Data would suggest that consumers have the best confidence when it comes to Emergency Care. According to the PRC 2008 National Consumer Perception Study, about 68% of consumers feel they know the best place to go for minor emergencies, while 65% believe they know the best place to go for trauma or major emergencies. When it comes to hospital services, obstetrics and gynecology have the highest patient satisfaction scores with a mean of 86.4 according to the Press Ganey 2008 Pulse Report. Additional information is available at www.prconline.com/studyreport and www.pressganey.com

Awareness of Best Hospital for Various Treatment Areas

"Yes" responses when asked "Do you know which hospital is best for certain treatment areas?"

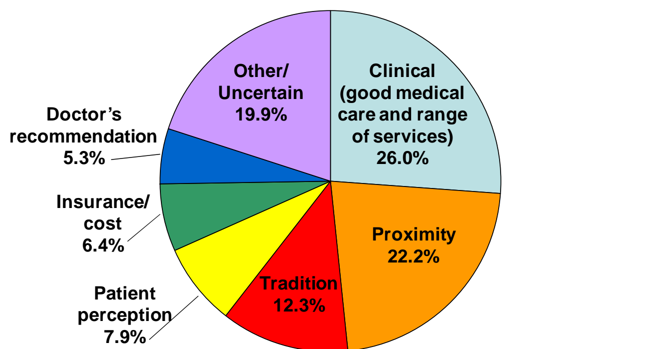
Treatment area	Yes
Minor emergencies	68.3%
Trauma/major emergencies	65.3%
Heart problems	63.8%
Major surgery	61.1%
Maternity care	58.4%
Open heart surgery	56.8%
Outpatient surgery	56.2%
Cancer Care	53.9%
Orthopedics	52.8%
Gastrointestinal problems	45.1%
Psychiatric care	29.9%

Source: PRC National Consumer Perception Study, 2008; hhnmag.com



Source: hhnmag.com

Main Reasons for Hospital Preference



Source: PRC National Consumer Perception Study, 2008; hhnmag.com

Top 10 Specialties by Overall Patient Satisfaction

Specialty	Mean satisfaction score
Obstetrics/Gynecology	86.4
Intensive Care Unit	85.7
Cardiology/Coronary	85.3
Rehabilitation	84.8
Pediatrics	84.5
Urology/Renal	84.4
Orthopedics	84.3
Oncology	84.1
Neurology	83.1
Pulmonary/Respiratory	82.2

Source: Press Ganey, Hospital Pulse Report, 2008; hhnmag.com

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OUR FOCUS

With over twenty-five 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. Some of our current projects include:

- Business development strategies for hospitals, health systems, medical practices, emerging healthcare companies and healthcare related businesses
- Development of Heart Centers/Heart Hospitals, Enhancement of Cardiac Servicelines and Vascular Centers, Development of Strategic Alliances and new Business Ventures
- Group practice management enhancements and clinical practice assessments, compensation modeling
- Development of physician-hospital alignment strategies and the formation of governance and management structures for such – (Co-management agreements; New management companies, etc.)
- Leadership programs/educational forums for healthcare industry executives, trustees, directors and clinicians. In depth exploration of major trends impacting healthcare
- Executive and career mentoring/coaching for physicians and healthcare executives
- Temporary management of Heart and Vascular Centers
- Hospital and medical practice quality reporting initiatives

EXAMPLES OF RECENT RINER GROUP SPEAKING ENGAGEMENTS

• "The Future of In-House Imaging, Will It Remain Viable?" – American College of Cardiology's Strategies for Success

• "Designing Your Healthcare Organizations' Physician-Hospital Management Structure, What It May Look Like in 2010" – AHA Society for Healthcare Strategy and Market Development

• "Transitions in Traditional Hospital Business Models: The New Frontier in Hospital-Physician Relations with New Responsibilities for Trustees" – Center for Healthcare Governance

• "Trends Impacting Healthcare Delivery" – Chief of Staff Meeting for Health Management Associates, Inc.

• "Compensation & Partnership Models for CV Practices" – Society for Cardiovascular Angiography & Interventions

• "Exploring the Role of Physicians on Hospital and Health System Boards" – American Hospital Association

•"The Challenge and Opportunity of Enhanced Physician – Hospital Partnering"

• "The Impact of Increasing Physician Workforce Shortages" – Board Retreats at numerous programs provided for health system boards and trustees

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Our PRIORITY ... excellence in the business and science of medicine.
Our SPIRIT ... superb patient care.