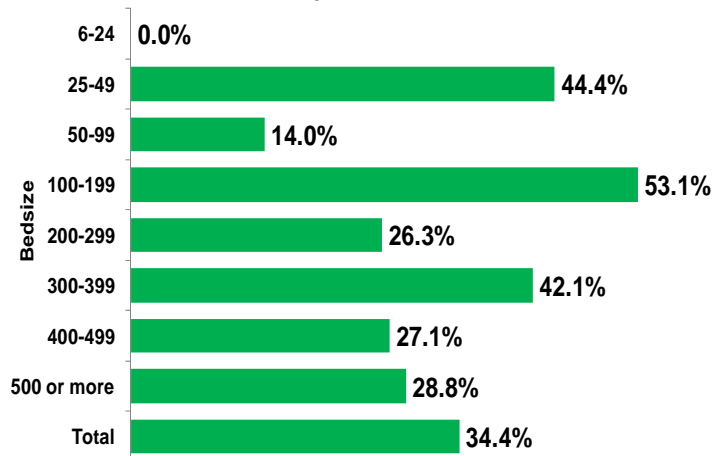




## INTENSIVIST SPECIALTY CONTINUES TO GROW

### Growth in Intensivists by Hospital Bedsize, 2007-2009

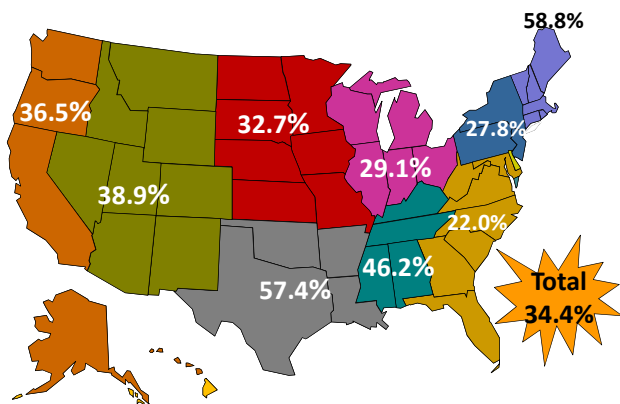


According to the Leap Frog Group for Patient Safety, ICUs staffed with Intensivists (also known as critical care physicians) can reduce mortality by 40%. This practice also is endorsed by the National Quality Forum. Intensivists are physicians who usually complete a residency in internal medicine or pulmonary medicine, surgery or anesthesia, and a fellowship in critical care medicine.

Intensivists have a variety of employment models; those providing care in general ICUs are most likely to be a hospital or independent provider group.

### Growth by Region, 2007 - 2009

% change in hospitals, reporting intensivists provide care



### Intensivist Employment Models, 2009

Among hospitals reporting that intensivists provide care

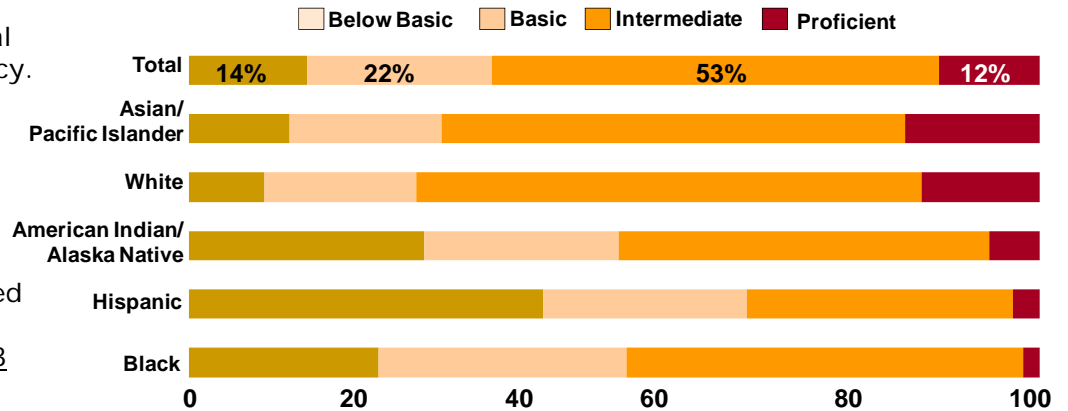
Employment model	Independent provider group	Employed by the hospital	Employed by a physician group	Employed by a university or school program	Other
Medical surgical intensive care	35.7%	34.5%	24.8%	8.33%	3.2%
Cardiac intensive care	26.9%	31.6%	21.9%	16.2%	6.4%
Neonatal intensive care	29.1%	30.4%	20.2%	16.9%	5.2%
Pediatric intensive care	15.7%	37.9%	17.1%	20.7%	10.4%
Other intensive care	18.3%	33.6%	21.3%	15.3%	13.8%



## A GROWING CONCERN OVER HEALTH LITERACY

There are many health disparities among patients, but one in particular is gaining international attention: Patient Health Literacy. Results of low health literacy include poor clinical outcomes; increased risk of hospitalization; increased all-cause mortality; frequent medication compliance errors; difficulty navigating the healthcare system; and increased out-of-pocket costs". It is estimated that an additional **\$73 billion** is spent each year in the U.S. due to low healthcare literacy.

### Percent Distribution of Health Literacy Level, 2003



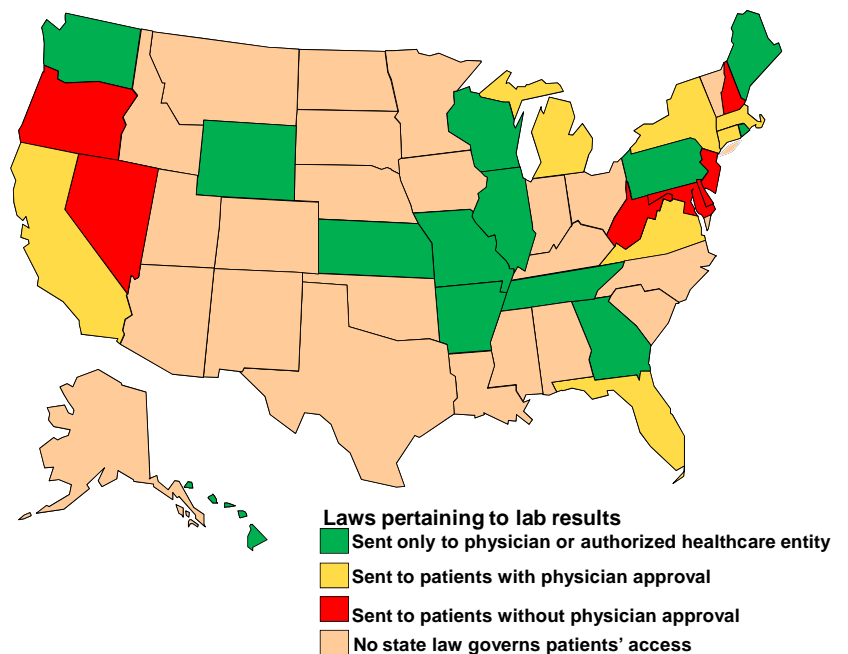
Percentages do not total 100 because of rounding.  
 The black & white categories exclude persons of Hispanic origin. Data are for persons age 16 years & over  
 Source: National Assessment of Adult Literacy (NAAL), National Center for Education Statistics (NCEDS), U.S. Department of Education. 2003 National Assessment of Adult Literacy. Department of Education

## TRANSPARENCY – PATIENT TEST RESULTS

Proposed changes to federal regulations would override existing laws in 20 states and give patients access to laboratory test results without having to first talk with the physician who ordered the tests.

How and whether patients are allowed to access their test results from clinical laboratories depends on the state or jurisdiction where the tests are performed. If rules proposed by the Department of Health and Human Services are adopted, patients across the country would have the right to obtain their lab results without physician approval. Some physicians are concerned that the information would be delivered without context or an explanation which in turn would then dictate additional visits.

### VARYING ACCESS TO LAB RESULTS



Source: "CLIA Program and HIPAA Privacy Rule; Patients' Access to Test Reports: A Proposed Rule by the Centers for Medicare and Medicaid Services," Federal Register, 9/14/11



## MANY ARE PRESCRIBED – SOMETIMES FEW ARE TAKEN

As many as half of Americans don't stick to their pharmaceutical orders. They fill about 20% to 30% of prescriptions written by doctors, don't take drugs as directed, and don't refill medications when they run out. (This is a major concern for physicians who will be held accountable for patient behavior in Accountable Care Organizations.)

Prescriptions that are not picked up or refilled may be able to be tracked using electronic medical records and prescribing technology. Clinical pharmacy specialists, case managers and other team members can follow up with reminders, phone calls and counseling to get patients back on their pharmaceutical regimens which leads to better health outcomes.

Research by the New England Healthcare Institute shows that patients who don't take their medications as prescribed cost the U.S. healthcare system an estimated \$290 billion in avoidable medical spending each year. A study published last January in *Health Affairs* shows that while improved medication adherence for four chronic diseases leads to higher spending on drugs, it also produces substantial savings because of less hospitalization and emergency department use.

Source: Wall Street Journal, 10/11/11

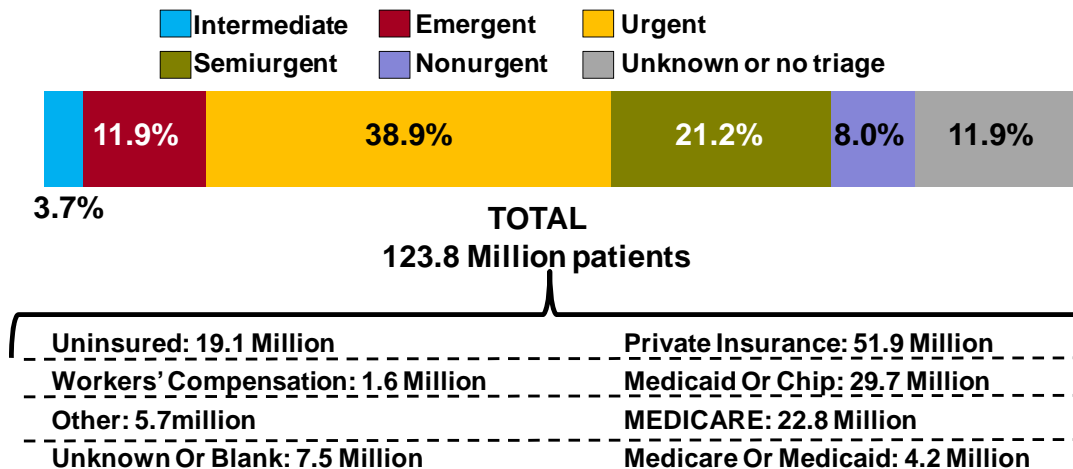
### Medication Nation

- **32 million Americans take three or more medications daily**
- **Nearly 75% of Americans report not always taking their medications as prescribed**
- **Almost 30% of Americans stop taking their medicine before it runs out**
- **Only about half of patients with high blood pressure take their prescribed dosages**

## NONURGENT ED VISITS – FEW AND FAR BETWEEN

Less than 10% of emergency department visits were nonurgent in 2008. The rate of nonurgent ED visits did not vary drastically among patients with different insurance coverage.

### Relatively Few Nonurgent ED visits



Numbers do not add up to 100% due to double counting in the categories.

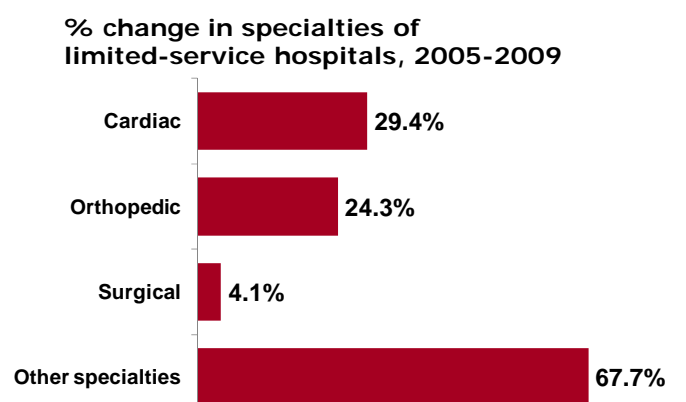
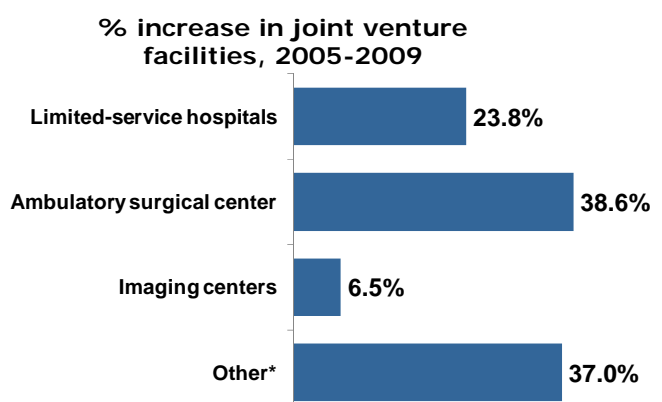
Source: National Hospital Ambulatory Medical Care Survey, Centers for Disease Control and Prevention, February 2011



## PHYSICIAN-HOSPITAL ARRANGEMENTS

Hospital joint venture activity and physician-hospital alignment structures have risen over the past couple of years. We are involved in advising hospitals, health systems, and medical groups through many of these activities.

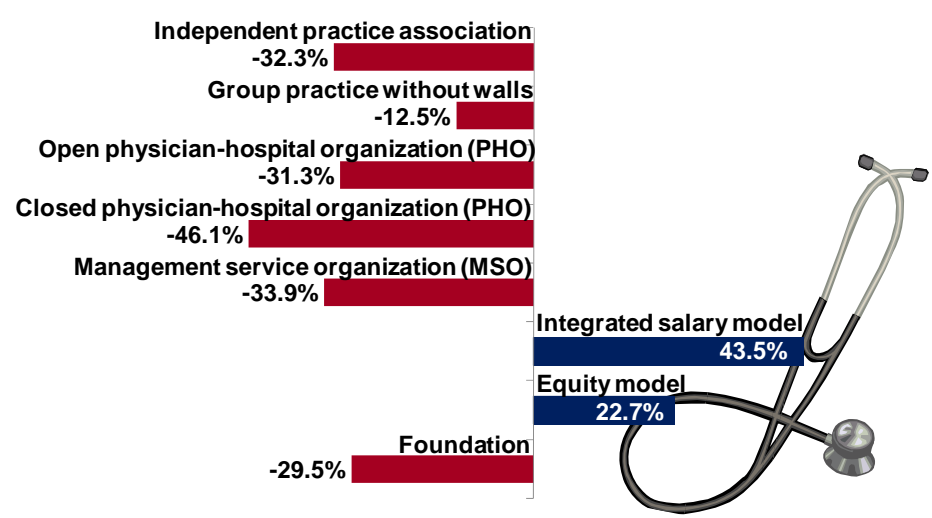
	2005	2006	2007	2008	2009	% change 2005-2009
Reporting hospitals	4,581	4,535	4,586	4,595	4,496	
Participate in joint venture	839	951	1,030	1,049	1,065	26.9%
Percent of reporting hospitals	18.3%	21.0%	22.5%	22.8%	23.7%	



\*Other is joint ventures including sleep lab, endoscopy center, cardiac cath lab, bariatric centers, mobile imaging equipment

Among hospital arrangements with physicians, the employed model, in which the hospital pays the physician a salary, shows the greatest growth over almost a decade.

	2000	2007	2008	2009
Reporting hospitals	4,747	4,585	4,595	4,496



Source: AHA Annual Surveys, 2000, 2005, 2006, 2007, 2008, and 2009

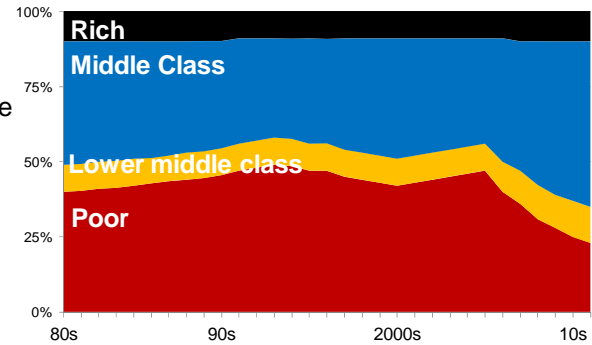


## MEDICAL TOURISM

The history of medical tourism continues to evolve. Some patients and payers are looking to countries outside the U.S. to provide high cost surgical procedures. Innovative healthcare systems in the U.S. are beginning to adopt the “medical tourism” concept and applying it to domestic patients and payers. It should be noted that in our cost constrained environment, many health systems are looking outside the U.S. to expand their service portfolio and expertise. Middle class salaries and lifestyles appear to be growing in certain sections of the world, especially South and Latin America, providing opportunities for people to seek care in this country and business opportunities for those interested in pursuing such in those areas of the world.

### EXPANDING MIDDLE

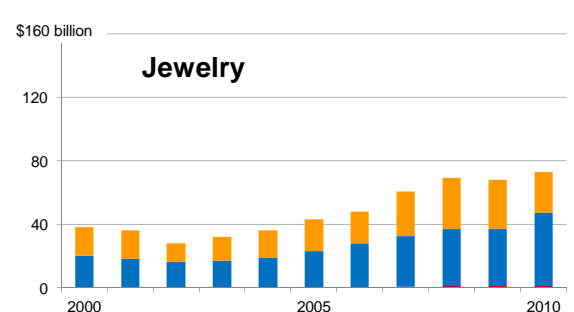
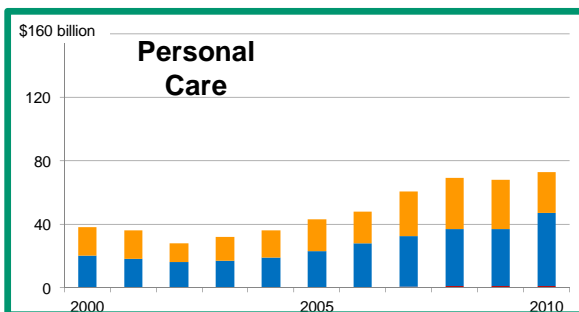
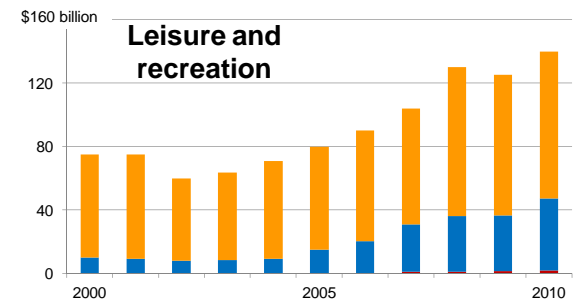
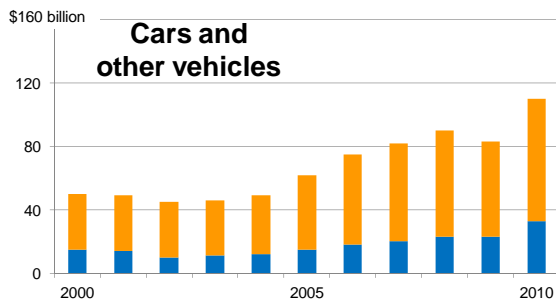
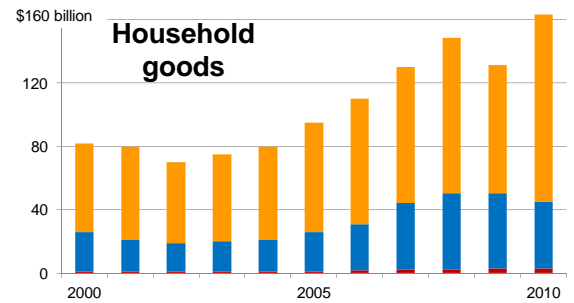
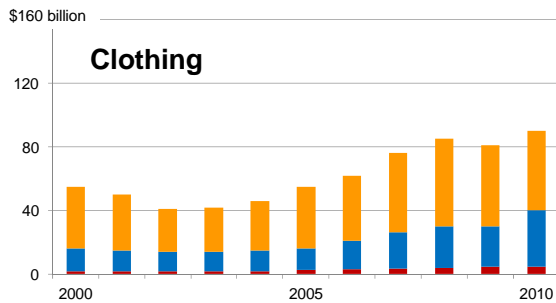
Latin America's middle class is steadily growing, while the poorest class is diminishing



Note: Data are projections after 2010  
 Source: Banco Santander, WSJ, 11/15/11

### SHOPPING SPREE – CONSUMER SPENDING IN LATIN AMERICA IS ON THE RISE

■ Peru ■ Brazil ■ Latin America



Source: Euromonitor International; WSJ, 11/15/11



## MOVE FOR PRICING TRANSPARENCY

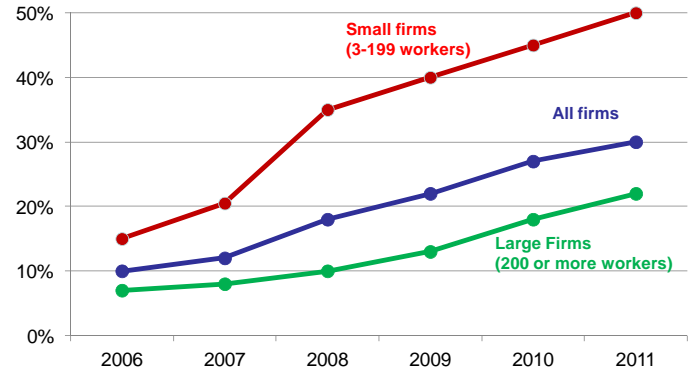
As employers rush to reduce their healthcare coverage expenses, there is increased pressure on insurers to be transparent about pricing. Just how much information employers can provide to workers about the cost of their medical care is also under review.

With employers pushing for pricing transparency, several major insurers are scrambling to upgrade their web based services to provide better details about cost. In addition, outside companies including Castlight Health Inc; Thomson Reuters Corp; Change Healthcare Inc; and CareOperative LLC's Healthcare Blue Book are competing to offer their own online pricing tools to employers.

The issue is rising because of a major shift in health insurance plan design: more and more Americans have high deductible insurance that requires them to pay cash out-of-pocket before coverage begins. These consumers are spending their own money on services, such as imaging tests, and therefore wish to shop around.

### OUT OF POCKET

Percentage of covered workers enrolled in a plan with an annual deductible of \$1,000 or more for single coverages



Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006-2011

## A PHYSICIAN'S CHANCE FOR A MALPRACTICE CLAIM

Specialty	% sued	% making payment
Neurosurgery	19.1%	3.1%
Thoracic-cardiovascular surgery	18.9%	3.8%
General surgery	15.3%	4.2%
Orthopedic surgery	14.2%	3.9%
Plastic surgery	12.7%	2.8%
Gastroenterology	11.6%	1.3%
Obstetrics/gynecology	11.0%	2.9%
Urology	10.5%	2.5%
Pulmonary medicine	9.3%	0.9%
Oncology	9.1%	1.9%
Cardiology	8.6%	1.0%
Gynecology	8.3%	3.2%
Neurology	7.8%	1.4%
Internal medicine	7.7%	1.3%
Emergency medicine	7.6%	1.4%
Anesthesiology	7.3%	1.6%
Diagnostic radiology	7.2%	1.6%
Ophthalmology	6.7%	1.2%
Nephrology	6.0%	0.4%
Pathology	5.6%	1.3%
Dermatology	5.4%	1.2%
Family general practice	5.2%	1.0%
Pediatrics	3.1%	0.5%
Psychiatry	2.6%	0.5%
Other specialties	4.0%	0.7%
<b>All physicians</b>	<b>7.4%</b>	<b>1.6%</b>

### LAWSUITS BY SPECIALTY

A study shows how often physicians by specialty are sued annually and how many end up making payments to plaintiffs who have sued them.

According to a study performed at Harvard Medical School, among physicians in high risk specialties such as neurosurgery, general surgery and OB/Gyn, an estimated 88% are projected to face their first claim by age 45 and an estimated 99% by age 65. In low risk specialties such as family medicine, pediatrics and psychiatry, 36% of physicians were projected to face their first claim by age 45 and 75% by age 65. The study analyzed claims data on 41,000 physicians from 1991-2005 from a large national malpractice carrier insuring more than 30,000 physicians in all 50 states and the District of Columbia. Frequency of suits did not impact payout as dermatology had the lowest average payout at \$117,832 and pediatrics the highest at \$520,923.

Source: *Malpractice Risk According to Physician Specialty,* "The New England Journal of Medicine, 8/18/11; American Medical News 9/12/11

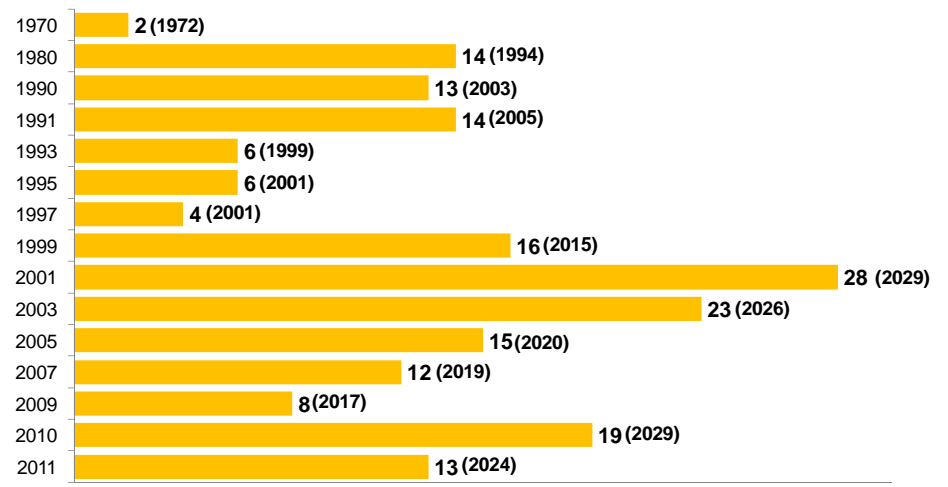


## FINANCIAL WOES FOR MEDICARE

### Solvency Projections of the Medicare Hospital Insurance Trust Fund, 1970-2011

Projected Number of Years to Insolvency and Projected Year of Insolvency

As our population ages, and more and more baby boomers enter the Medicare population, The Solvency Projections of the Medicare Hospital Insurance Trust Fund become very poignant. Funding Medicare is in reality a much greater problem than Social Security at this time.



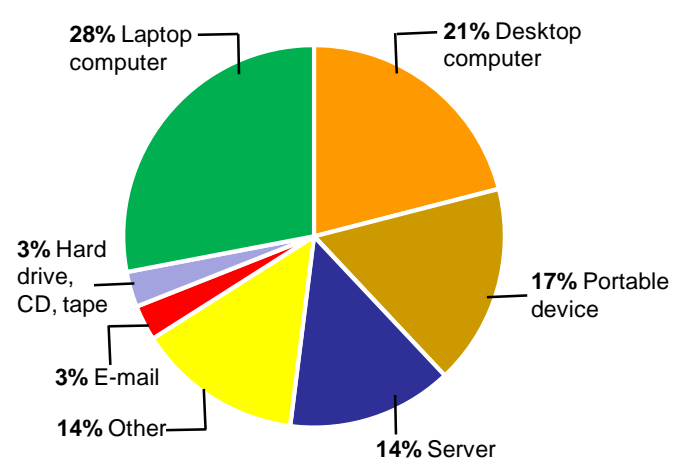
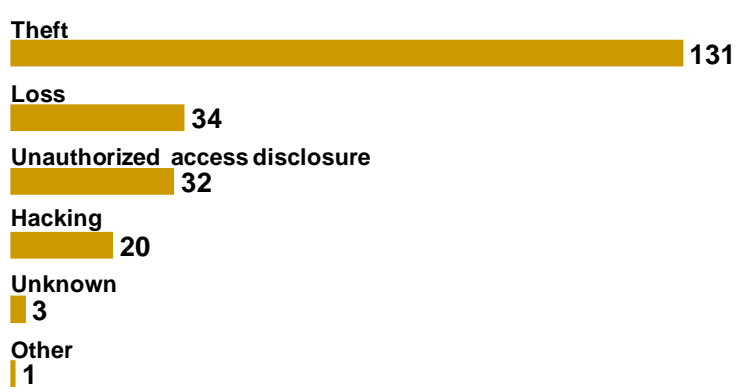
Source: Kaiser Family Foundation, May 25, 2011.

## CONCERNS FOR INFORMATION SECURITY

Despite this growing push for transparency in healthcare, including pricing, costing and the protected exchange of healthcare information across Health Information Exchanges (HIE) etc., there continues to be a major concern for the security of personal health information. Personal health information of 10.5 million patients was compromised in 203 breaches of unencrypted electronic data reported to HHS since notification became mandatory in 2009.

### LOST AND FOUND

The data breached was most often housed on hardware easily lost or stolen.



Note: Some incidents were tagged with more than one category

Source: "HHS Office for Civil Rights; Modern Healthcare, 5/23/11



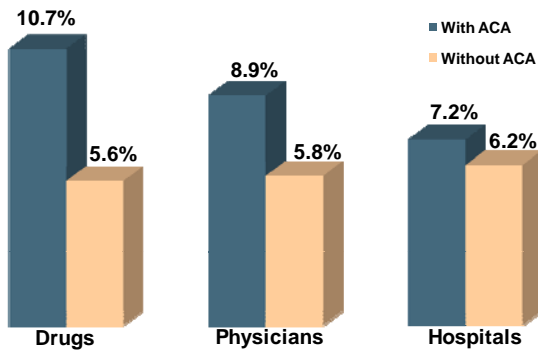
## NONPROFIT HOSPITAL REVENUE GROWTH

Nonprofit hospitals are under increasing financial pressure, with revenue growing at the slowest rate in at least two decades, according to a new report from Moody's Investors Service.

The 4% median revenue growth rate, based on a review of 401 hospitals' fiscal 2010 financial results, is the lowest the firm has seen since it started tracking the figure two decades ago. Though the hospitals have been pushing hard to reduce expenses over the past few years, around 20% of those in the study were still running in the red on an operating basis.

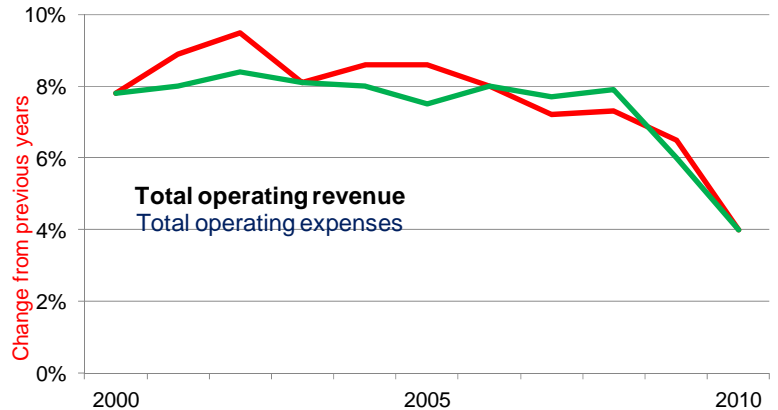
Nonprofits, including those owned by state and local governments, represent around 80% of the U.S acute-care hospitals, according to the American Hospital Association.

### GROWTH SPURTS IN SOME SECTORS



### HEALTH CHECK

Growth of nonprofit hospitals' revenue and expenses has slowed



Source: Moody's, WSJ, 8/10/11

Spending on care outside of hospitals and on prescriptions is expected to rise more quickly as a continued transformation of place occurs from the inpatient environment to the outpatient environment, and as more Americans gain coverage under provisions of the Affordable Care Act.

Source: CMS Office of the Actuary; Modern Healthcare 8/1/11

## A BIG PHARMA CHALLENGE

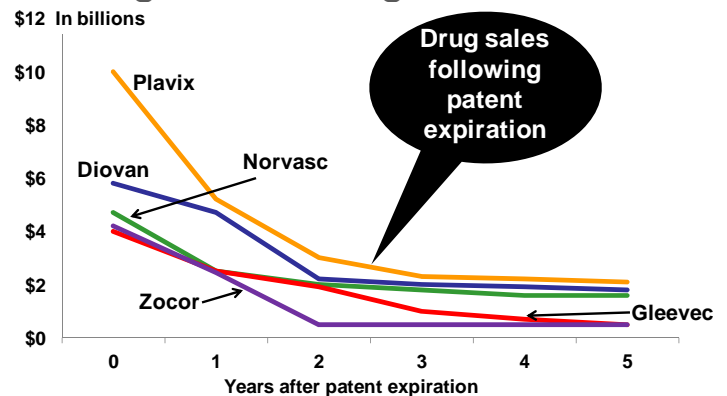
With blockbuster drugs poised to come off of patent protection and increasing pressure on pharmaceutical pricing, the industry is focusing on innovation, research and growth strategies. These graphs highlight big pharma's problems and key drugs that are on the patent cliff edge.

### At the Patent Cliff's Edge

Year expiring	Drug/Company	2010 Sales
2011	Lipitor (Pfizer)	\$10.7b
2011	Seroquel (AstraZeneca)	\$5.3b
2011	Zyprexa (Eli Lilly)	\$5.0b
2012	Diovan (Novartis)	\$6.1b
2012	Plavix (Bristol-Myers Squibb, Sanofi)	\$9.4b

Data Bloomberg Company Reports

### Big Pharma's Big Problem



Source: Bloomberg Businessweek, August 8-14, 2011

Note: Estimated Sales Data Bloomberg Company Reports Page 8



## THE HELPING HAND OF THE MIDDLELEVEL PROVIDER

Almost one in two office-based physicians works in a practice that includes physician assistants, nurse practitioners and/or certified nurse midwives. And that number is expected to go up.

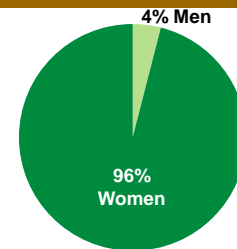
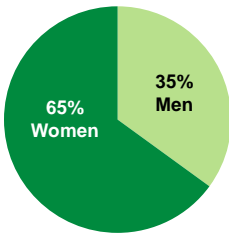
The Centers for Disease Control and Prevention's National Center for Health Statistics reported recently that 49% of physicians working in office settings have the practitioners as part of their practice. Most likely to work with them are physicians age 54 and younger, those in large groups, and those serving a large Medicaid population. The data shows a brief snapshot of physicians' assistants and nurse practitioners.

*\*Sources: American Academy of Physician Assistants, American Academy of Nurse Practitioners, Modern Healthcare, 5/23/11*

### Physician Assistants

### Gender

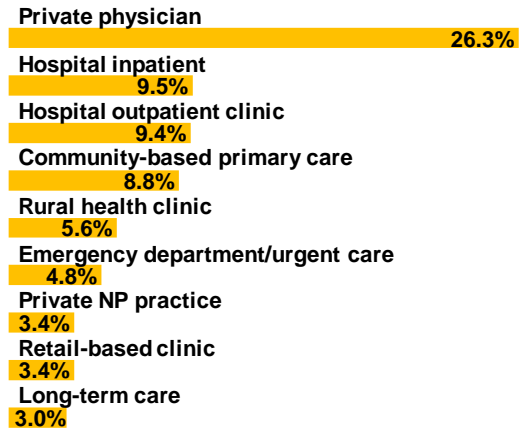
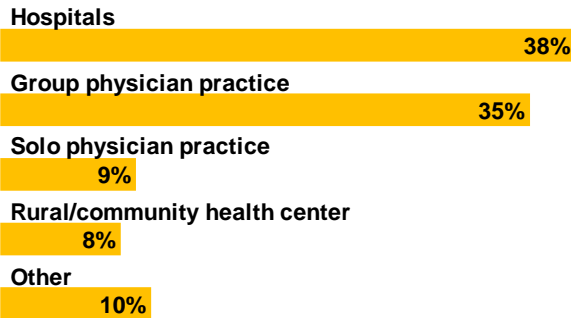
### Nurse Practitioners



### Physician Assistants

### Practice Settings

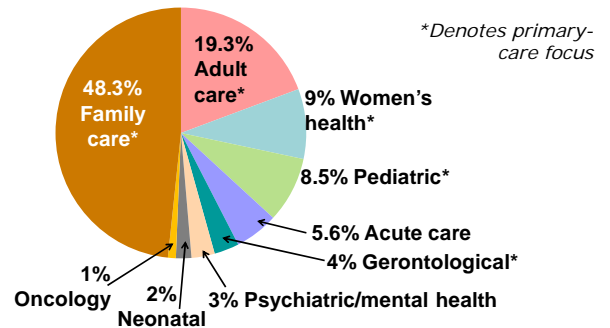
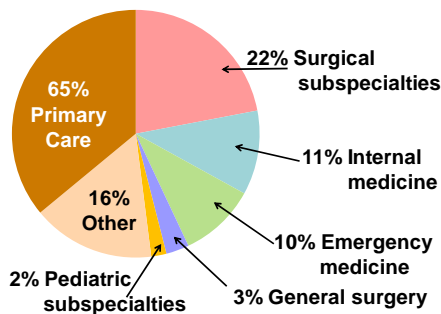
### Nurse Practitioners



### Physician Assistants

### Specialties

### Nurse Practitioners



### Physician Assistants

### Average Salaries

### Nurse Practitioners

Emergency medicine	\$102,018
Surgical subspecialties	\$99,968
General surgery	\$92,429
Internal medicine subspecialties	\$88,214
Pediatric subspecialties	\$87,674
Primary care	\$85,461

Emergency medicine	\$118,380
Inpatient hospital, critical care	\$109,140
Inpatient hospitalist team	\$102,580
Private physician practice	\$93,190
Retail-based clinic	\$92,770
Community health center	\$89,560



## CONTRACT RESEARCH ORGANIZATIONS ADAPT

As pharma activities narrow, contract research organizations are rapidly increasing their offerings. In its goal to advance safe, effective and profitable drugs to market, the pharmaceutical industry has long acknowledged contract research as an essential resource. To remain competitive, pharmas are being forced to evolve significantly or abandon traditional approaches in favor of new R&D models. We have long worked with contract research organizations and note that CROs effectively span the full range of drug discovery and development services. Those that provide the full range of services are an elite group, and most CROs can provide some means of specialization. CROs will continue to be a significant partner to big pharma in bringing new medicines and new pharmaceutical therapies to the marketplace.

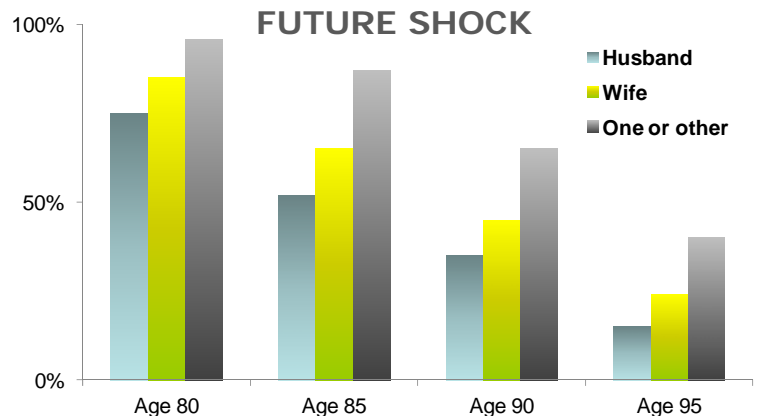
Source: GEN (General Engineering & Biotechnology News), May 5, 2011

## PLANNING FOR THE LONG TERM

In our discussions about economics, Medicare funding, and reimbursement constraints, it is important to remember that our population as a whole is aging. This needs to be factored into all strategic discussions, especially for healthcare providers and healthcare strategists.

A 65 year old couple today faces an 8 in 10 chance that one of them will live to 85; the chance that one will reach 97 is 1 in 4. In a 2009 survey by the society of actuaries, only 7% of retirees said they are planning out for 20 years or more. Among pre-retirees just 13% are thinking two decades ahead.

Source: Money, June 2011



## DO WE NEED TO REDESIGN EVERYTHING OR MERELY BE EFFICIENT?

Healthcare costs are without question a topic of discussion or as is commonly said, “the elephant in the room.” Debate revolves around whether we need to redesign the way physicians interact with patients or should all of us become extremely cost-conscious. Providing cost-conscious care should be the 7<sup>th</sup> general competency for physicians, according to a recent article in the September 20<sup>th</sup> issue in *The Annals of Internal Medicine*. The approach includes reducing unnecessary industry tests to cut an estimated \$700 billion in wasted healthcare spending annually. Obviously, that entails a complete look at our healthcare system, including malpractice issues and resetting the expectations of our patients. About a decade ago the Accreditation Council for Graduate Medical Education and the American Board of Medical Specialties defined six general competencies that were critical for a physician to acquire during training. These were:

- Medical knowledge
- Patient care
- Professionalism
- Interpersonal and communication skills
- Practice-based learning and improvement
- Systems-based practice.

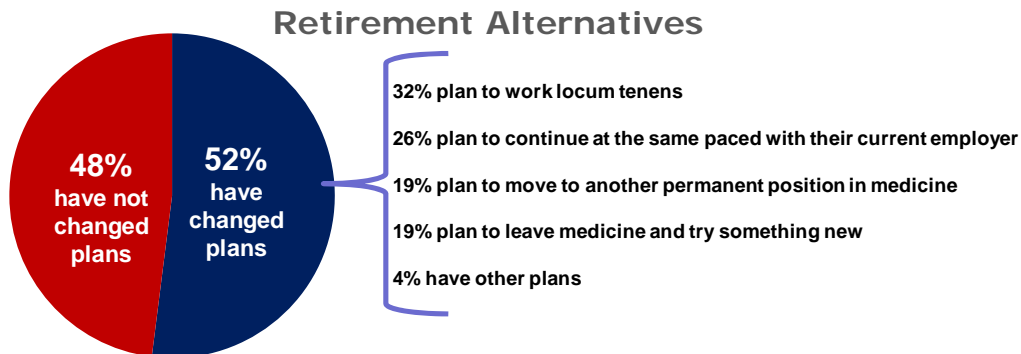
Currently residents are expected to factor in cost awareness as part of the systems-based practice competency, but there are suggestions that this is insufficient. Efforts to teach cost-effective care, or prompt it through audits, have not been successful. The practice habits that are developed during medical school, residency and fellowship training are frequently noted to persist throughout a career. Efforts are underway to focus more rigidly on teaching cost-effective care.

Source: Money, June 2011 Cardiovascular Business 9/27/1



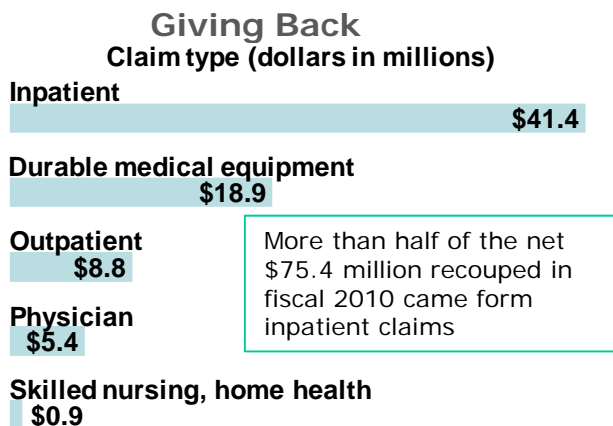
## DID YOU KNOW?

- **Status of the Economy**– The current status of the economy has disrupted many doctors' retirement plans. According to a survey issued recently by the physician staffing agency, Jackson & Coker, 52% of 522 doctors responding had changed their retirement plans since the 2007-2009 recession. About 70% of those said they will work longer because personal savings had been impacted negatively. This will have major implications for projected workforce shortages.

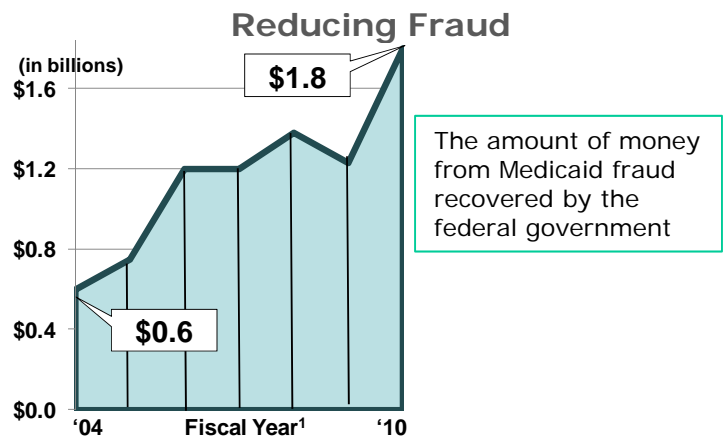


Source: Jackson & Coker Retirement Survey, 8/2/11; American Medical News 9/12/11

- **Quality Incentives** – The percentage of organizations offering physicians a salary combined with a bonus structure has stopped increasing over several years of growth. These plans are placing greater emphasis now on factors that probably will play a role in reimbursement under health system reform. The facts come from a recent survey of 182 healthcare organizations released by the Hay Group in 2011 indicating that 66% of groups used quality measures in determining an annual incentive and 62% used patient satisfaction. There is a clear movement toward inclusion of quality and satisfaction data as part of the total compensation package.
- **Good News** – The prevalence of coronary heart disease (CHD) in the U.S. declined from 6.7% in 2006 to 6% in 2010, according to a report released in October 2011 by the Centers for Disease Control and Prevention (CDC).
- **Your Tax Dollars at Work** – Audits have turned up more than \$680 million so far in Medicare payment errors. The first report to Congress on Medicare's Recovery Audit Contractor (RAC) Program, released in September covering the 2010 fiscal year, provides an overview of the first year of audits. Federal officials are moving to broaden audits under Medicare and expand them to Medicaid as Congress seeks ways to curb federal spending. The federal government has more than tripled the amount of money it has recovered through its efforts.



Source: CMS; Modern Healthcare 10/10/11



<sup>1</sup>Fiscal year begins Oct 1

Source: Dept. of Health and Human Services; USA Today, 10/20/11

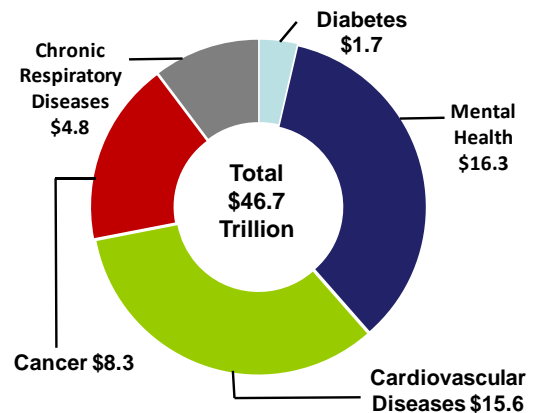


## DID YOU KNOW?

- Disease Burden**– Projected lost economic output caused by non-communicable diseases from 2011 - 2030 approaches \$47 trillion worldwide. Non-communicable diseases account for about 36 million deaths, or about 63% of total deaths worldwide per year. Nine million of those deaths occur in people under 60 years old. More than 80% of deaths from these diseases occur in developing countries, and the burden of chronic disease is growing in places such as China and India.

Source: Harvard School of Public Health; World Economic Forum; WSJ, 9/19/11

### Looming Burden Projected lost economic output caused by non-communicable diseases, 2011-2030, in trillions



## HOW CONTINUING MEDICAL EDUCATION IS FUNDED

Year	Total CME funding	Industry support	Ad & exhibit revenue	Registration fees & other revenue
2006	\$2.38 billion	\$1.19 billion	\$245 million	\$940 million
2007	\$2.54 billion	\$1.21 billion	\$274 million	\$1.05 billion
2008	\$2.37 billion	\$1.04 billion	\$277 million	\$1.05 billion
2009	\$2.18 billion	\$856 million	\$283 million	\$1.05 billion
2010	\$2.24 billion	\$831 million	\$277 million	\$1.13 billion

Source: Accreditation Council for Continuing Medical Education 2010 Annual report data, 8/11/11; amednews.com, 9/12/11

- Continuing Education** – Commercial support is down nearly a third since 2007. Revenues from physicians, medical schools, hospitals, and other sources now pay for 51% of accredited CME. With industry support falling to \$830 million – 31% lower than high-water mark of \$1.2 billion in 2007 – CME providers are relying on the fees they charge physicians. These fees are \$20-\$50 per credit hour. Annual requirements range from 15-50 credit hours depending on the state.

- Pace of Mergers and Acquisitions** – Physician practices are the fastest growing segment of healthcare mergers and acquisitions, based on a year-over-year growth in the number of transactions, according to a recent report by Irving Levin Associates. In the second quarter of 2011 they counted 27 mergers and acquisitions, worth \$416 million. That was up 200% from the nine deals Irving Levin counted in the second quarter of 2010, after the Patient Protection and Affordable Care Act was passed.

Physician practice purchases were highest 14 to 15 years ago, when the physician practice management industry was at its peak. There is currently the feeling that the scale provides leverage. Many of the physician practices are confronted with issues such as aging practitioners who do not wish to make investments in the technology necessary to provide electronic health records; absence of younger physicians willing to buy in and therefore an absence of an exit strategy; overwhelming administrative burdens; lack of leadership or willingness within the practice to assume the leadership responsibilities of running a private business.

Mergers and acquisitions are occurring in other sectors as well. The most active sectors by number of deals were long term care (38); followed by medical devices (36); hospitals and pharmaceuticals (each with 32). Medical devices (\$33.1 billion) and pharmaceuticals (\$27.4 billion) dominated in terms of cash value of deals, making up 82% of the dollar amount, though only 28% of the deals.

Source: American Medical News 8/8/11



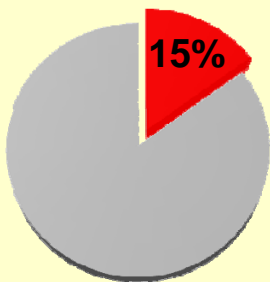
## DID YOU KNOW?

- **Claim Denial** – Patients who appeal denials directly to insurers win 39%-59% of the time depending on the state (only 4 states collect relative data), according to a recent report from the Government Accountability Office.

### Why One Should Appeal

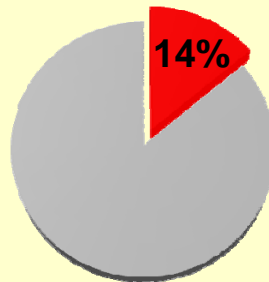
Data is from Maryland, one of the few states to collect it.

#### Insurers Reject Lots of Claims



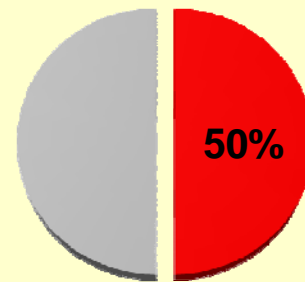
Percentage of health claims that are denied

#### When it's because care isn't deemed necessary, few people fight back



Percentage of such denials that are appealed

#### That's a Mistake



Percentage of such appeals to insurers that are successful

Notes: Data from 2009 Denials based on insurers' determination that a proposed or delivered healthcare service is not medically necessary. Successful appeals data based on internal appeals filed with insurer. Source: Maryland Insurance Administration, HEALTH, September 2011

- **Administrative Costs Continues to Rise** – The administrative costs that U.S. physicians, and those in small practices in particular, incur while dealing with payors are nearly 4 times the cost seen by their Canadian counterpart, according to a report in *Health Affairs*. Researchers from Cornell University, the Medical Group Management Association and the University of Toronto place payer-related administrative costs for U.S. doctors at \$82,975. They compared this to an estimated \$22,205 for the cost of time spent by Canadian physicians and medical staff interacting with provincial single-payer health plans. (The estimate is based on 216 surveys from physicians in Ontario completed in the second half of 2006.)

If the 454,000 office-based physicians had administrative costs comparable to those of their Canadian counterparts, the total savings would be \$27.6 billion a year.

Source: *Modern Physician* 8/4/11

- **Brain Research and The Challenge of Aging** – Living longer demands that we urgently address diseases of the brain that often accompany aging. Three out of five Americans will suffer from a nervous system disease at some time in their lives. These illnesses are often chronic and debilitating. The list of these ailments is long – Alzheimer's disease and Parkinson's disease being among the most widely known and there are no cures for many of them. For Alzheimer's and Parkinson's there are medicines that diminish the symptoms, but these drugs do not alter or even slow the underlying degenerative process.

Today over five million Americans suffer from Alzheimer's and over one and a half million from Parkinson's. Alzheimer's disease is rare before 60, but afflicts about one in twenty by age 70 and one in three by 85. With even a modest increase in life expectancy over the next 40 years, life expectancy will nearly triple the number of people in the U.S. with Alzheimer's, and that means huge expenditures. Therefore, an aging population that escapes cancer, heart disease and stroke and lives to 85 will have a 35% chance of developing Alzheimer's disease. Research on Alzheimer's and Parkinson's disease consumes less than 2% of the entire National Institute of Health's (NIH) budget.

Source: *WSJ*, 7/5/11



## DID YOU KNOW?

- Buried in Administrative and Regulation Requests** – Unfunded mandates, lack of health insurance standardization, and too many incentive programs add costs and inefficiencies to physician practices according to the findings of recent surveys provided by the American Medical Association. The survey received more than 2,000 responses from physicians and feedback from state and medical specialty societies. Topping the list of burdens was unfunded mandates such as providing translators for Medicare and Medicaid patients with hearing impairments or limited English language skills. Other burdens included drug plan authorizations, documentation requirements, and competing incentive programs. All of these issues and administrative headaches are leading physicians to consider abandoning the practice of medicine or positioning their practices within larger organizations where the administrative burden is shifted to others.

### Hospital Employment – Salary Expectations

Hospital Employment / By The Numbers	
<b>45%</b>	Physicians who expect an annual salary increase who have accepted a position as a hospital employee
Those who would expect no change in salary	<b>38%</b>
<b>17%</b>	Those who would accept a decreased salary
Median salary increase expected by family physicians for hospital employment	<b>2.9%</b>

Source: PwC Health Research Institute April 2011 survey of 1,000 U.S. physicians

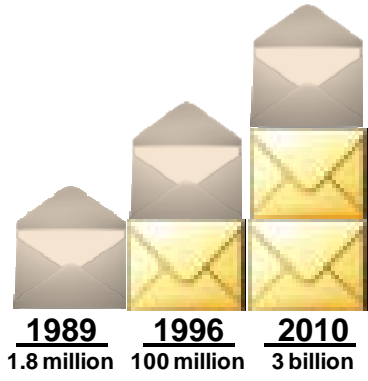
- Cardiac Rehab** – Patients who undergo angioplasty (PTCA or PCI) to unblock clogged arteries have better odds of survival if they participate in a cardiac rehabilitation program afterwards. These findings from a 15 year analysis of 2,400 patients who underwent PCI were recently published in a May edition of the journal *Circulation*. The study found that 44% of the patients had participated in at least one session of cardiac rehabilitation program, which typically includes education, exercise programs, nutrition counseling, assistance in quitting smoking and weight control therapy to evaluate patient progress. Overall, researchers discovered a 46% relative reduction in death from all causes in patients who participated in a rehab program following an angioplasty.



## DID YOU KNOW?

- Change is a Constant** – To join an email list before 1986, users had to wait for someone to painstakingly adjust the code to include them. The brief graphs below give a snapshot of how our electronic digital world is changing.

### Worldwide Email Accounts



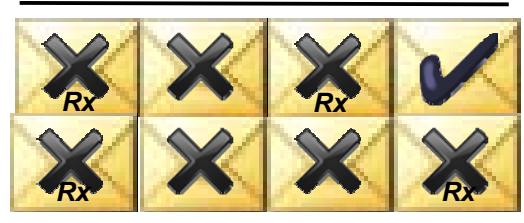
### From 2009 to 2010, email use by . . .



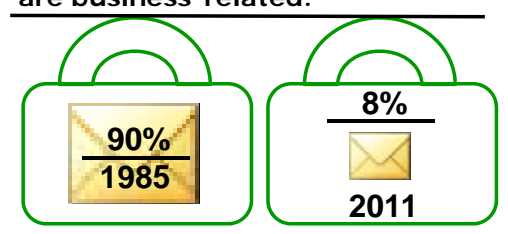
The average businessperson sends 33 emails each day



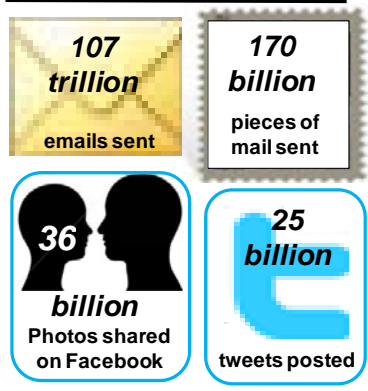
89% of all sent emails are spam, the majority of which are pharmaceutical promotions



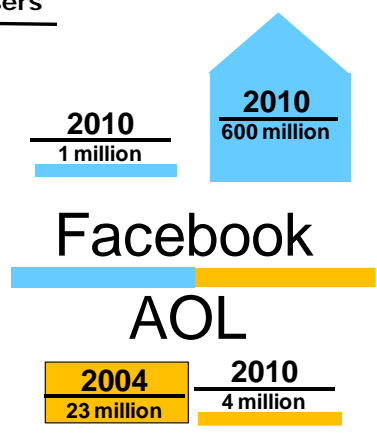
In 1985, 90% of all emails were business related. Today, just 8% are business related.



In 2010, there were . . . .



Users



Source: FASTCOMPANY.com, 6/2011



## OUR QUICK POLL RESULTS

The following question was posted on the Riner Group Website for the months May – July 2011.

### Who is primarily responsible for dealing with the obesity epidemic in this country?

Without question America has an obesity problem. Some debate whether it is actually a disease or a behavioral issue that we as a society are contending with and will contend with. With two-thirds of the U.S. adults now classified as obese or overweight, public health officials are warning that much of the population is at high risk for diabetes, heart disease and other chronic and costly illnesses.

There are a host of recent released plans suggesting that the government will enter into a series of public policy measures ranging from taxes on soda, better school lunches and mandatory listing of calories on menus, fitness friendly infrastructure and restrictions on “junk food” advertising. On the other hand, there is a growing group of individuals who are beginning to tout that it is the individual’s responsibility to look after their weight and personal health.

Advocates of anti-obesity policies say the government has a responsibility to intervene when taxpayers pick up much of the nation’s obesity-related healthcare costs calculated at \$147 billion in 2008 by the Centers for Disease Control and Prevention (CDC). The counter to these government mandated programs is outlined in a recent book entitled “Obesity Myth” by Paul Campos. He states that these types of initiatives reflect the refusal to accept the ineffectiveness of population-wide weight reduction programs. He is a University of Colorado law professor and bases much of his pessimism on long term health interventions by prominent institutions such as Johns Hopkins University and the University of Minnesota that resulted in improved health behaviors but no weight loss. He also notes that the most reliable CDC data show a plateauing of obesity rates over the last decade.

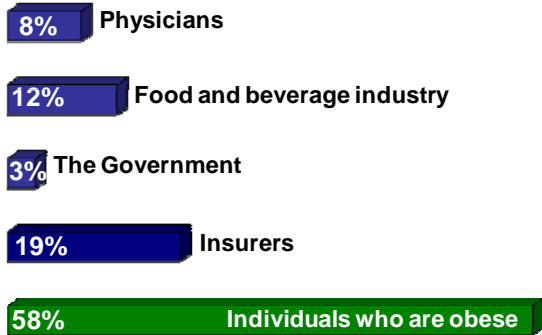
Books such as “Obesity Myth” and others state that it is difficult to understand how to make obese individuals thin and how to keep thin people from getting fat on a population-wide basis. These types of statements are often considered heretical and anathematizing to say in these public policy debates, but it’s a critical detail that tends to get ignored frequently by policymakers. Much of what we are currently recommending as interventions has been tested repeatedly in the past and frankly has not been shown to work.

Promoters of public policy state that some of the strategies currently being promoted, such as calorie labeling requirements at chain restaurants, have not been tried previously. These types of calorie labeling will go into effect nationally in 2012. New voluntary guidelines and advertising “junk food” to children were also released recently over protests by the food industry.

All parties are advocating greater education on nutrition. However, many are skeptical that education may not be enough. For example, many knew that it was unhealthy to smoke, but it was only when high tobacco taxes were added that a difference in quit rates and reducing the initiation of smokers was actually observed, especially in vulnerable populations like young people or those with low incomes. Most observers agree that obesity is a more complicated issue than smoking and that prohibitive high taxes on soda and junk food would be difficult to pass and would likely not solve the problem.

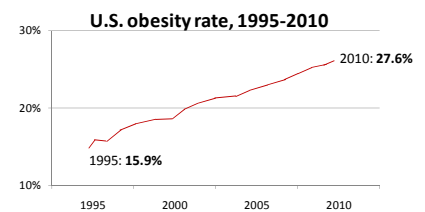
This debate will continue and needs to be focused upon as we look to the future. There are pros and cons to both sides, but the concern from a physician vantage point is that we are forgetting to put individual responsibility into the equation. Indeed, as we discuss entities such as Accountable Care Organizations (ACOs), behavioral modification and individual responsibility is completely lacking. In fact, physicians and other healthcare providers are being placed in the responsible role of changing behavior for financial incentives. The medical community is beginning to push back and to ask where individual responsibility lies for adherence to medications, exercise and changing behavioral consumption of adverse foods.

Watch for this debate to continue. Payors, the government, physicians, individuals and the food and beverage industry all have their perspectives and vantage points. The Riner Group’s vantage point is that the individual will need to take a greater role in modifying behavior to improve healthcare outcomes.



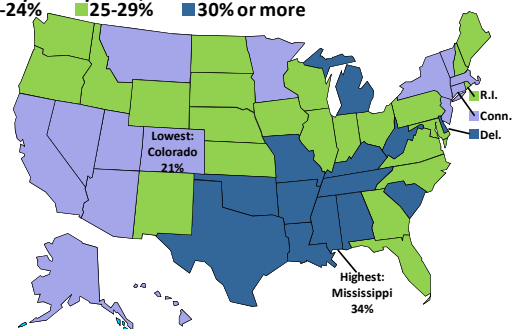
#### Big Problem in the U.S.

The U.S. obesity rate has nearly doubled since 1995. Obesity is defined as having a body mass index reading of 30 or more. BMI measures the proportion of weight to height



#### Obesity rate by state, 2010

■ 21-24% ■ 25-29% ■ 30% or more





## SPEAKING ENGAGEMENTS

Dr. Riner and his colleagues frequently speak at events across the U. S. The topics offer interesting perspectives on healthcare issues for you to share with your colleagues or to strategize for the future of your practice or healthcare organization. Some examples of recent presentations which coincide with our work include, but are not limited to:

- Impact of Healthcare Reform on Small Business
- Successful Physician Recruitment, What You Need to Know About Working With Physicians
- Trends Impacting Medical Practice
- Healthcare Delivery Future – What’s the “Skinny!”
- Leadership Tactics for Success
- Team Building – A Physician’s Perspective of Physician/Hospital Alliances
- MD Communication – A Pragmatic Approach to Enhanced Patient Satisfaction
- Emerging Models of Medical Practice and Healthcare Delivery +/- Health Reform
- The Affordable Healthcare Act: What You Need to Know
- Physician Hospital Alignment – What, Why, When, Who, How
- Structuring Communication for a Hospitalist Program
- Teamwork – Lessons from the Trenches. How to Form Effective Healthcare Teams
- A Board Approach to Growth and Alignment Strategies in Healthcare – What the Board Needs to Know

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

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## 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.

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