



Mediscene Newsletter

Volume 29 Issue 1

May 2008

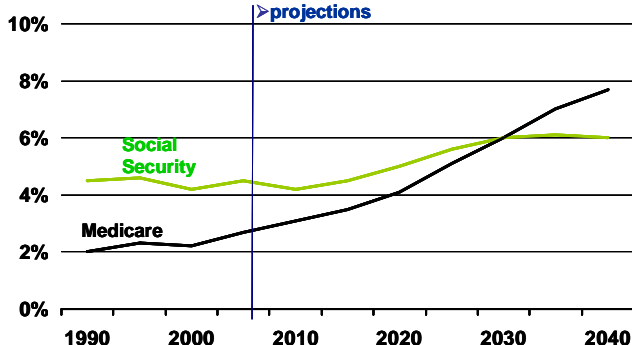
IT'S THE SAME STORY – RISING COSTS

Social Security trust funds are set to run out of money by 2041, according to the latest annual report from the Board of Trustees for the funds. The Medicare Trust Fund is expected to become insolvent earlier, by 2019, largely because of rising healthcare costs. The trustees of Social Security and Medicare again recently sounded the alarm about the program's financing challenges.

The cost of insuring aging baby boomers will help push up national healthcare expenditures in the next decade. Two main factors are driving up costs: the aging population and the rising price of new drugs and medical technology.

SAME STORY RISING COSTS

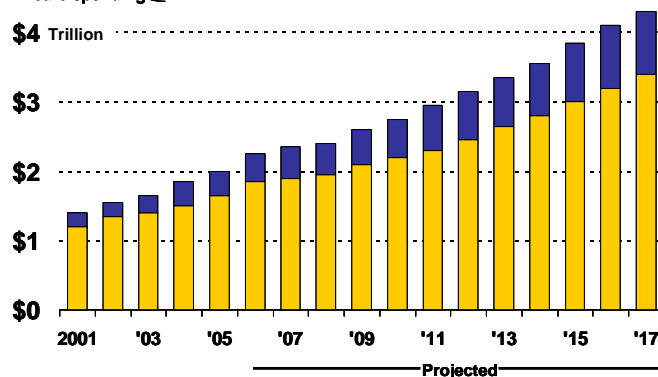
Social Security and Medicare spending as a percentage of gross domestic product



The Riner Group, Inc. Source: Social Security & Medicare boards of trustees; WSJ 3/26/08

FOOTING THE BILL

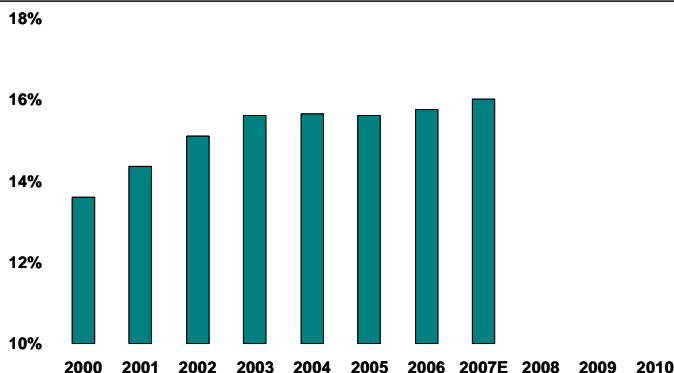
Total health-care spending



The Riner Group, Inc. Source: Centers for Medicare & Medicaid Services; WSJ 2/26/08

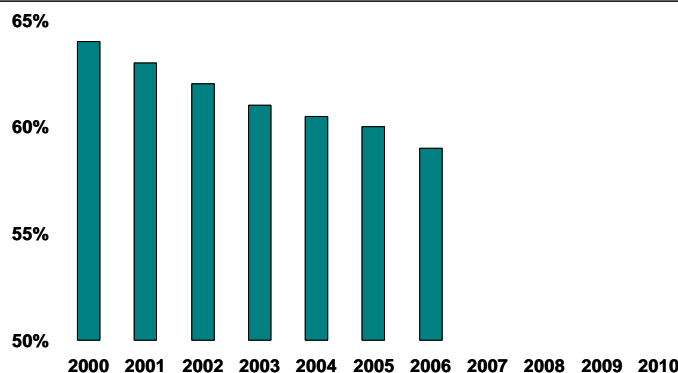
As a consequence healthcare is an issue for millions of Americans because at the same time that medical costs have been rising Americans receiving coverage through their employer has declined as noted in these graphs.

U.S. NATIONAL HEALTH EXPENDITURES AS A PERCENTAGE OF GDP



Source: Centers for Medicare & Medicaid Services, Office of the Actuary; The Riner Group, Inc. Citigroup Global Markets/Equity Research

EMPLOYER-BASED HEALTH COVERAGE



Source: Centers for Medicare & Medicaid Services, Office of the Actuary; The Riner Group, Inc. Citigroup Global Markets/Equity Research



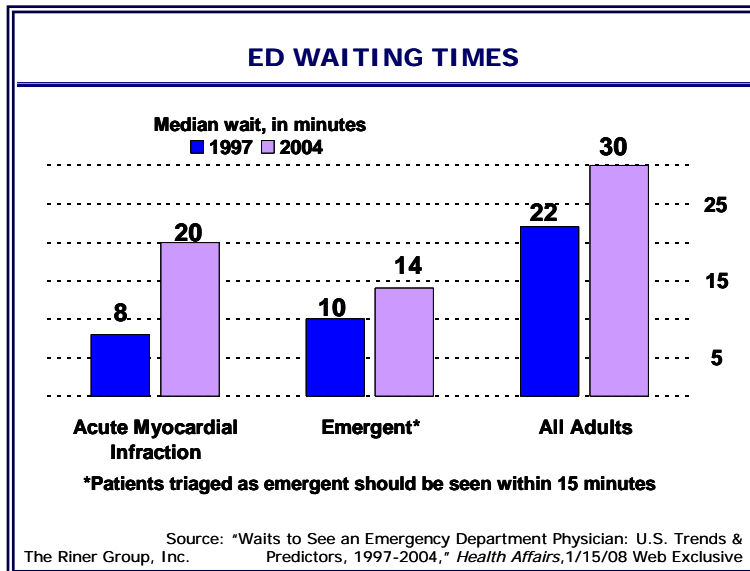
Mediscene Newsletter

Volume 29 Issue 1

May 2008

ED SERVICE

Hospital emergency departments are overburdened all across the country. From 1994-2004 the total number of ED visits increased about 18% while the number of EDs dropped by as much as 12%. This translates into longer waits for patients according to a Health Affairs study in the January 15, 2008 which looked at wait times after triage.



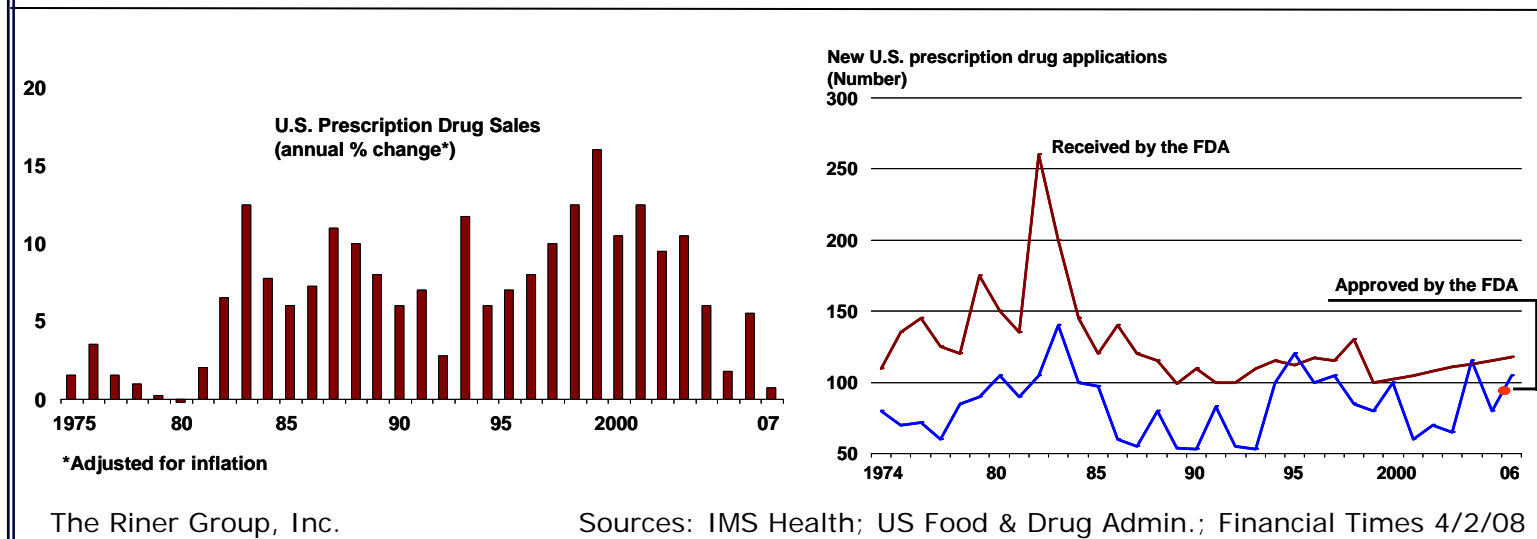
PHARMACEUTICAL COMPANY HEALTH

Pharmaceutical companies saw a 3.8% increase in sales in 2007, the smallest increase since 1961, according to IMS Health, the largest pharmaceutical data provider. Factor in inflation and sales grew by less than 1%.

The data suggests the drug industry had an unprecedented two-decade expansion that is unlikely to be repeated soon. Between 1983 and 2003 the inflation adjusted sales grew, on average, 10% a year. The long term average for the industry, dating back to the start of IMS record keeping in 1956, is 6% and growth since 2003 has averaged half that.

The 1983-2003 boom was fueled by two big developments. The first was scientific – during this period the drug companies developed and tested new classes of drugs including statins for reducing cholesterol, the first widely accepted anti-depressant, gastric reflux treatments, and new arthritic drugs. The second reason was a huge marketing campaign with special emphasis on direct-to-consumer advertising which tripled to \$3.3 billion between 1997 and 2003, according to the U.S. Government Accountability Office.

PHARMACEUTICAL METRICS





Mediscene Newsletter

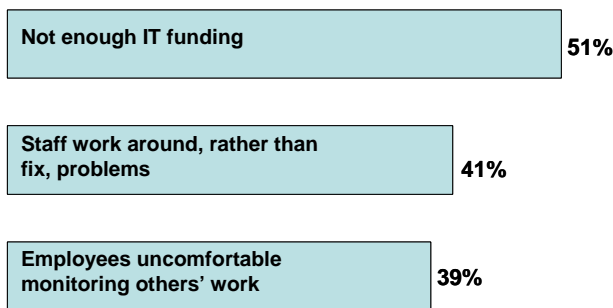
Volume 29 Issue 1

May 2008

SAFETY

This graph shows the top three factors that hamper safety efforts cited by roughly 450 hospital Chief Executive Officers surveyed.

FACTORS HAMPERING SAFETY EFFORTS



Source: American College of Healthcare Executives;
Modern Healthcare 1/7/08

The Riner Group, Inc.

KEEPING CEOs UP AT NIGHT

When asked to name their top three challenges in a recent survey undertaken by the American College of Healthcare Executives CEOs listed the following.

CEO CONCERNS

Financial challenges	70%
Care for the uninsured	38%
Quality	35%
Physician-hospital relations	33%
Personnel shortages	30%
Patient safety	29%
Governmental mandates	22%
Patient satisfaction	17%
Capacity	11%

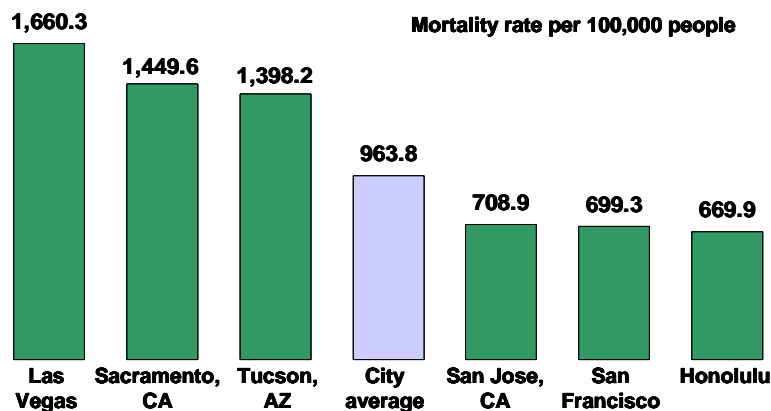
Source: American College of Healthcare Executives;
Modern Healthcare 1/7/08

The Riner Group, Inc.

WHAT HAPPENS IN VEGAS . . .

Las Vegas is the least healthy metropolitan area in the country and Honolulu is the most healthy, according to the new ranking of the 54 largest metro areas in the country.

HEALTH OF NATION'S CITIES



Source: Big Cities Health Inventory, 2007, National Association of County & City Health Officials;
Modern Healthcare 11/5/07

The Riner Group, Inc.



Mediscene Newsletter

Volume 29 Issue 1

QUALITY FOCUS

May 2008

The Joint Commission report, *Improving America's Hospital: The Joint Commission Annual Report on Quality and Safety 2007*, indicated that while hospitals have made strides on heart attack, heart failure, pneumonia care and surgical care, their compliance rates remain low in the majority of measures related to those four areas.

The report includes the status of the Commission's National Patient Safety Goals (NPSG), a series of measures that highlight specific practices in areas of care for greater improvement. Compliance with the goals – in 2006 it was 16 requirements and 7 goals – is mandatory for accreditation.

EVIDENCE-BASED CARE		
Measure	Percentage compliance	Percentage point change from 2005
Heart attack care	94.4%	4.4
Pneumonia care	87.3%	6.3
Pre-surgery antibiotic given	84.7%	4.9
Heart failure care	84.1%	8.1
Post-surgery antibiotic ended	78.9%	5.4

Source: Improving America's Hospitals: The Joint Commission's Annual Report on Quality and Safety 2007; *Modern Healthcare* 11/19/07
The Riner Group, Inc.

EMR UPDATE

According to the Medical Records Institute's annual "Survey of Electronic Records Usage", the percentage of doctors who reported funding and resource barriers to purchasing EMRs decreased, as did the percentage reporting lack of support from staff or partners. After vendor and consultant responses were removed to reduce survey bias there were 729 respondents to the survey in 2006 and 819 in 2007. The Institute is an organization that promotes technology use in healthcare.

This table shows lack of funding and lack of resources remain the chief barriers to implementation, say physicians who have installed or are installing EMRs.

WHY YOU NEED AN EMR, WHAT'S STOPPING YOU			
ADVANTAGES	2006	2007	
Improved patient documentation	Not asked	81.2%	
Improved workflow efficiencies	81.7%	73.1%	
Remote access to patient records	Not asked	72.1%	
Improved coding & charge capture	60.0%	64.2%	
Point-of-care access & transmission of patient data	Not asked	63.2%	
Patient & physician satisfaction	52.6%	61.5%	
Decision support & clinical guidelines	Not asked	52.6%	
Easier reports (e.g., government, payers)	Not asked	50.1%	
Increased revenues	Not asked	44.9%	
Computer & Internet support for decision-making	Not asked	37.5%	
Expanding medical community with links to hospitals, other services	Not asked	33.3%	
Value-based purchasing/pay-for-performance	33.0%	33.1%	
Improved competitiveness	44.4%	30.4%	
Pressure from government, insurers	6.9%	19.9%	
Possibility of subsidized purchase	15.8%	19.5%	
BARRIERS	2006	2007	
Lack of adequate funding or resources	55.5%	40.4%	
Anticipated difficulties in changing to an EMR system	Not asked	30.9%	
Difficulty in creating migration plan from paper	22.9%	29.3%	
Inability to find an EMR solution or components at an affordable cost	29.4%	29.1%	
Difficulty justifying the investment	21.0%	23.7%	
Unable to find EMR that meets needs	23.6%	21.1%	
Difficulty finding an EMR that is not fragmented among vendors or IT platforms	23.2%	19.0%	
Lack of support by medical staff or partners	31.7%	18.8%	
Difficulty evaluating EMR solutions or components	23.6%	18.5%	

Source: "Survey of Electronic Medical Records Trends & Usage," Medical Records Institute; amednews.com
The Riner Group, Inc.



Mediscene Newsletter

Volume 29 Issue 1

May 2008

MEDICAL TOURISM UPDATE

While global medical tourism has as yet to make major in-roads with U.S. employers, some small employers and benefit providers such as Blue Cross Blue Shield of Texas are starting to take the idea seriously. Experts predict that the medical tourism industry will grow to \$40 billion by 2010.

MEDICAL TOURISM HOT SPOTS

WHERE U.S. patients are going and for what specialty

1. BRAZIL: Dentistry
2. COSTA RICA: Dentistry
3. INDIA: Hip replacements & heart surgery
4. SINGAPORE: Knee replacements
5. SOUTH AFRICA: Cosmetic & reconstructive surgery
6. THAILAND: Cardiac, orthopedic, & spinal surgeries

The Riner Group, Inc. Source: FSB, May 2007

SAVING MONEY

To combat rising medical costs Americans are pursuing a variety of remedies – including a few that may not be in their best interest from a health standpoint.

- 78% have switched to generic drugs
- 66% talk to their doctors about cost
- 64% go to the doctor only for serious symptoms
- 28% skip doses or have not filled prescriptions

HOW PATIENTS SAVE ON HEALTHCARE

78%	66%	64%	28%
Have switched to generic drugs where available	Talk to their doctors about cost and options	Go to the doctor only for serious symptoms	Have skipped doses or have not filled prescriptions

The Riner Group, Inc. Source: Employed Benefit Research Institute 10th Annual Report, Jan. 2008



Mediscene Newsletter

Volume 29 Issue 1

May 2008

EXPENSIVE MEDICAL CONDITIONS – THE FACTS

Heart disease is the most expensive medical condition in the U. S., according to new data from the Agency of Healthcare Research and Quality.

The figures based on 2005 data, show that the nation's ten most expensive medical conditions costs about \$500 billion to treat. This includes costs of visits to the doctor's office, clinics and emergency departments, hospital stays, home health care, and prescription medicine. Heart conditions top the list with costs totaling \$76 billion.

TOP 10 MOST EXPENSIVE MEDICAL CONDITIONS IN U.S.	
Top 10 most expensive medical conditions in U.S.	
Condition	Cost
Heart conditions	\$76 billion
Trauma disorders	\$72 billion
Cancer	\$70 billion
Mental disorders including depression	\$56 billion
Asthma chronic obstructive pulmonary disease	\$54 billion

The Riner Group, Inc. Source: Heartwire 2008 of WebMD

HOSPITALISTS PHENOMENON

There are now about 20,000 hospitalists, four times as many as there were in 2002. Nearly half of all U. S. hospitals have them and the percentage tops 70% among larger institutions. About a third of hospitalists work directly for hospitals, and 20% are on the faculty of academic medical centers. Most of the others are associated with local hospitalist groups and regional or national hospitalist companies. Only 1% work for HMOs, compared with 9% in 2002, according to a report in the February 15, 2008 issue of *Medical Economics*.

A study of 76,926 hospital patients treated by either a hospitalist, general internist or family physician found that hospitalists' patients typically stayed in the hospital about a half day less, though the cost of care did not vary much.

Some of the major benefits attributed to hospitalist care revolve around quality of life for physician groups that used to have to attend patients in the hospital setting. We predict that the hospitalist trend will continue to permeate acute care facilities throughout the country.

COMPARING OUTCOMES			
	Hospitalist	Internist	Family physician
Total adjusted costs per patient	\$5,129	\$5,397	\$5,254
Length of stay in days	2.9	3.3	3.3

The Riner Group, Inc. Source: "Outcomes of Care by Hospitalists, General Internists & Family Physicians," *New England Journal of Medicine*, 12/220/07; amednews.com



Mediscene Newsletter

Volume 29 Issue 1

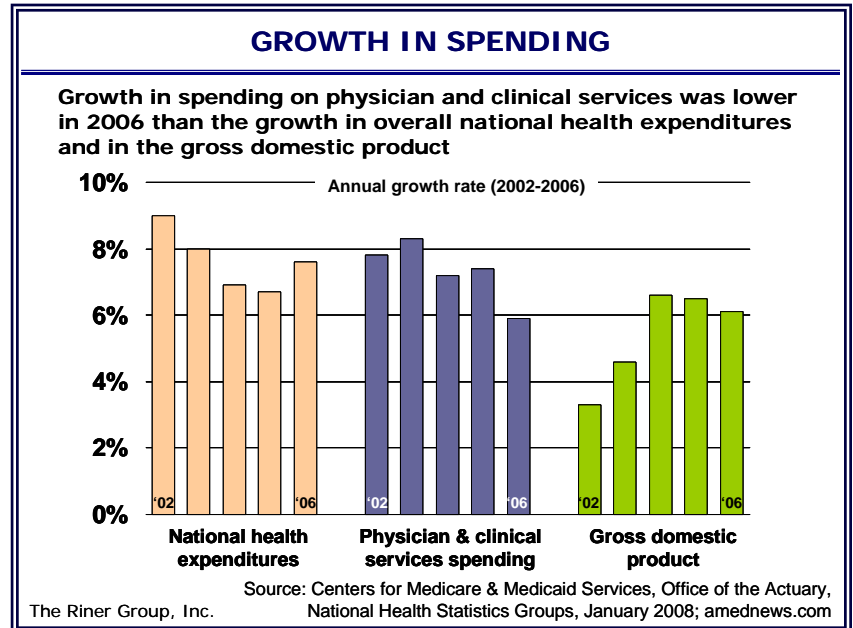
May 2008

HOW PHYSICIANS FARE

While the national health spending growth rate increased slightly in 2006, the percentage rise in expenditures on physician services slowed markedly, due largely to small Medicare pay increases and its private-sector fallout, according to a new report by the Centers for Medicare and Medicaid Services.

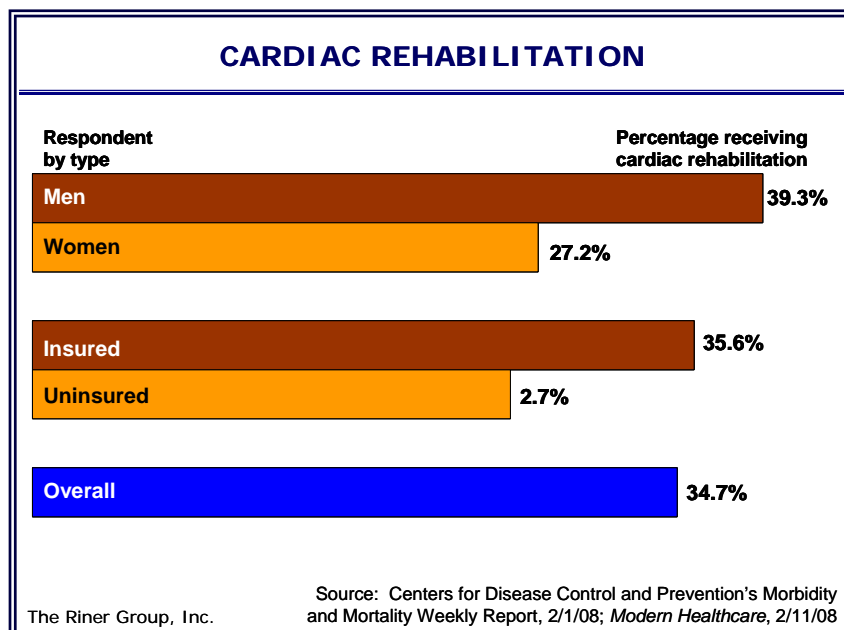
At the same time the start of Medicare Part D had a major impact on the prescription drug factor.

Overall national health spending reached \$2.1 trillion, up 6.7% from \$1.97 trillion in 2005, according to the CMS report which was published in the January/February *Health Affairs*.



THE REHAB STORY

A large majority of Americans who experience a heart attack do not receive cardiac rehabilitation, with variations found depending on gender and insurance coverage, according to a new report based on a random telephone survey of almost 130,000.





Mediscene Newsletter

Volume 29 Issue 1

May 2008

IN THE MONEY

The seven largest health plans in the U.S. recently reported their earnings for 2007. Revenue was up for every company compared to 2006. California based Health Net was the only one of the big insurers to post a drop in earnings from 2006-2007, due to paying three large settlements in class action law suits. Revenue and income totals are shown in millions.

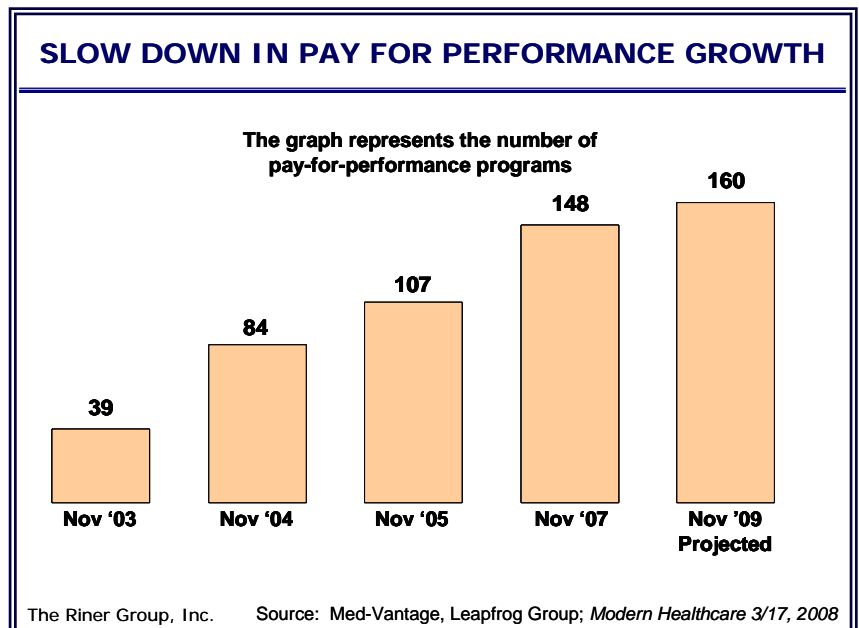
IN THE MONEY								
Company	2006 revenue	2007 revenue	Change	2006 net income	2007 net income	2006 earnings per share	2007 earnings per share	Change
Aetna	\$25,145.7	\$27,599.6	9.8%	\$1,701.7	\$1,831.0	\$2.99	\$3.47	16.1%
Cigna	\$16,547.0	\$17,623.0	6.5%	\$1,014.0	\$1,110.0	\$3.43	\$3.87	12.8%
Coventry	\$7,733.8	\$9,879.5	27.7%	\$560.0	\$626.1	\$3.47	\$3.98	14.7%
Health Net	\$12,908.4	\$14,108.3	9.3%	\$329.3	\$200.2	\$2.78	\$1.76	-36.7%
Humana	\$21,416.5	\$25,290.0	18.1%	\$487.4	\$833.7	\$2.90	\$4.91	69.3%
UnitedHealth Group	\$71,542.0	\$75,431.0	5.4%	\$4,159.0	\$4,654.0	\$2.97	\$3.42	15.2%
WellPoint	\$57,038.8	\$61,134.3	7.2%	\$3,094.9	\$3,345.4	\$4.82	\$5.56	15.4%

Source: Company Filings with the Securities & Exchange Commission; amednews.com

The Riner Group, Inc.

SLOWDOWN IN PAY FOR PERFORMANCE

The number of pay-for-performance programs nearly quadrupled from 2003 to 2007, but the rapid growth appears to be flattening as healthcare policy experts begin to acknowledge some of the complications and difficulties of pursuing this tactic. Some of those issues are focusing on treatments that generate rewards, or in some cases no longer treating very ill patients or the homeless, since this population could lower performance scores. More broadly, some suggest incentive programs aren't doing enough to address problems of racial and ethnic disparities as well.





Mediscene Newsletter

Volume 29 Issue 1

DID YOU KNOW?

May 2008

- International student enrollment in U.S. graduate schools increased. The total enrollment of international students at U.S. graduate schools increased 7% from 2006 to 2007, after rising just 1% the year before, according to the Council of Graduate Schools (CGS). Total enrollment of students from China and India, the two countries that send the most students to the U.S., rose by 15% and 14% respectively. In its latest report the CGS noted that 87% of U.S. graduate school deans participated in some type of international outreach or recruitment during the last two years and a substantial number have traveled overseas to do it. More than 1/3 of these deans reported attending international student recruitment fairs.
- Recruitment challenges continue to be an issue for most medical groups. A recent survey by The Delta Companies showed the following.
 - 73% say physician recruitment in 2007 was more challenging, up from 68% who said recruiting was getting more difficult in the 2006 survey.
 - 28% note that voluntary physician resignations have increased
 - 35% have a formalized medical staff retention program in place
 - 67% note that the use of temporary clinical medical staff has not increased from 2006, according to a recent study by researchers at the "Center for Studying Health System Change."
- There are some interesting trends occurring in how physicians are doing business
 - Physicians are moving into larger practices and losing affiliations with general hospitals, providing more ancillary services and investing in enterprises that frequently compete with hospitals for outpatient and inpatient services.
 - The payment system has not evolved to support changes in practice such as additional care coordination, to treat the growing number of patients with chronic diseases. As a consequence patient selection is impacting the financial and clinical metrics of medical practice.
 - More disturbingly some of these trends contribute to an increasingly tiered delivery system with physician-owned facilities and practices feeling constraints of economic reimbursement, tending not to serve Medicaid or Medicare beneficiaries. There is increasing prevalence of physicians opting to drop contracts with insurers to receive higher out-of-network payments from patients. This contributes to disparities in access. (*Health Affairs*, December 2007)
- The number of medical graduates in primary care residencies rose 6% during the 11-year stretch that closed in 2006. For experts who say the nation faces a shortage of such doctors that figure may appear hopeful. However a closer look would suggest that without foreign medical graduates, the U.S. saw no change in the primary care residents in 2006 compared with 1995. An increase in international graduates masked a 7% drop-off in U.S. graduates entering primary care training according to a recent Government Accountability Office Report.
- As of 2006, 93 of the nation's 126 medical schools increased or are planning to increase enrollment over the 2002 levels, according to a recent report entitled Medical School Expansion: Challenges and Strategies, released in January 31, 2008. There continues to be a debate as to whether there is a shortage of physicians vs. a maldistribution. Some question whether predictions of shortages take into account the potential leverages of technology and need level providers that will be applicable as one looks to the future. In fact some feel we may actually have a surplus of physicians in certain specialties – even specialties that are currently touted as showing a shortage.



Mediscene Newsletter

Volume 29 Issue 1

DID YOU KNOW?

May 2008

• The first physician satisfaction survey on insurers has been made public. The Harris County (Texas) Medical Society recently gave poor marks to six Houston area health insurers, saying the companies have failed patients, employers, and doctors on patient-care, payment and customer service issues. Some of the highlights of the survey included:

- More than 65% of the doctors reported experiencing difficulty getting their patients' medical services approved.
- Some 69% have problems with prompt payment, and 64% said they are paid less than their contracted rate.
- On education, 58% say their patients do not understand benefits, co-payments, deductibles and limitations of their coverage.
- Moreover 65% of their patients rarely understand preventive services and care-coordination services available to them.

We would watch for this trend to evolve across the country as physicians begin to rank payers and make these data public. Insurers are just becoming increasingly aware that they may need good physician satisfaction scores to sell their products to the public and business.

• The participation in the Physician Quality Reporting Initiative (PQRI) would suggest just 16% of eligible providers – only 99,000 physicians, non-physician practitioners or therapists – submitted data at least once in 2007, according to the preliminary data released by the CMS last week on the PQRI. The voluntary program last year offered a bonus (1.5% of the total allowed charges for covered Medicare physician fee-schedule services payments) to practices that reported claims on a designated set of 74 quality measures. The agency doesn't know yet how much money it will be paying out to physicians for 2007 because some are still reporting, according to the CMS. An average family physician grossed perhaps \$400 to \$1500 for the six-month reporting period last year. Many physicians claim the amount of headache and hassle in reporting far outweighed the financial incentives that were available to them.

• There are now approximately 100 of the 150 U.S. medical schools that offer some variation of spirituality-in-medicine course work. 75 of those 100 require their students to take at least one course on the topic. In recent years, more research has examined the links between faith and physicians. In 2005, a nationwide study found that 76% of physicians believed in God, and 59% believed in an after life. Physicians are more likely to attend religious services than the rest of the U.S. population says a study in the July 2005 *Journal of Internal Medicine*.



Mediscene Newsletter

Volume 29 Issue 1

OUR QUICK POLL RESULTS

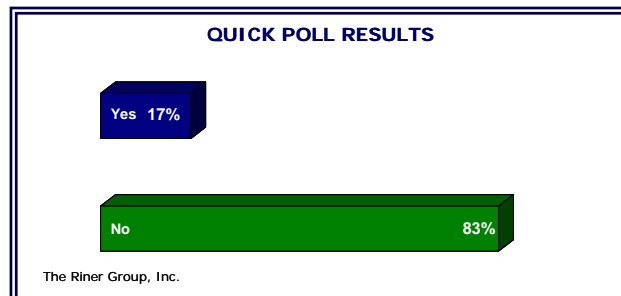
May 2008

The following question was posted on the Riner Group Website for the month of October 2007.

“Do you think the average person is capable of making informed decisions about medical studies and the statistics associated with such?”

Americans are frequently bombarded with news of medical breakthroughs every day. How can they judge which is deserving of attention? Meaningful studies are well designed, include hundreds of patients similar to the average individual (in age, sex, race, and state of disease) and have clear dramatic results. Physicians & hospital administrators should familiarize themselves with questions most patients will and should be considering along with their physician when investigating these matters. Patients should discuss the entire situation with their physician taking into account such things as personal healthcare, quality of life, costs, risks and benefits. Below is a list of questions individuals should ask concerning reported medical studies.

Questions to ask
Who were the subjects, researchers, and sponsors? Are the subjects similar to you? Do the researchers have appropriate credentials? Who funded the study? Could the researchers' financial involvement with a company or the sponsor's marketing motives have biased the research or reporting?
How was the study done? Was it a randomized trial, survey, or single-case report?
How many people were in the study? There's strength in numbers, and more is better. Was there an adequate number of participants to make statistically relevant statements concerning the findings?
Where were they studied? Primary care offices, or university clinics? Patients at large teaching hospitals often have more severe cases that aren't typical of smaller community settings.
What was studied? *POEMs* (Patient-Oriented Evidence that Matters) looks at medical events (outcomes) such as rates of heart attack or stroke. Other studies focus on test results like cholesterol levels or bone density. Test results can be important, but changes in serious health outcomes present stronger evidence.
When and for how long was the study done? Cholesterol measures can change in three months, but you may need three years to detect a change in heart attack rates.
What the technical terms really mean
 These are arranged in order from most- to least-desirable to describe types of healthcare studies.
Meta-analysis of systematic review of many similar studies pools results so researchers can analyze information from hundreds of thousands of patients.
Single randomized controlled trial (RCT). Researchers randomly divide patients into two groups. The experimental group receives a new treatment while the control (comparison) group receives either traditional care or an inactive treatment. The larger the eventual difference in results between the groups, the stronger the evidence.
Cohort study. A large group of people are followed, usually for years, to see how often a disease develops, and to learn which factors affect the disease.
Case-control study. This study compares past cases (people with disease) to controls (people without disease), searching for clues to why the disease occurs.
Cross-sectional studies look at a population at one point in time.
Small case studies describe only several patients with a particular disease.
Expert opinion is only as good as the evidence it's based on. Often, some of what's on the internet is from a BOGSAT – a Bunch Of Guys/Gals Sitting Around Talking.
Single cases or testimonials. Don't trust the claim: “It worked for me, it'll work for you, too!” – Maybe – BUT maybe not and may come with serious side effects.
How to interpret the math
Statistical significance, P<0.05. This means there's less than a 5% chance that the study's results are purely coincidence and more than a 95% chance that they're truly related to the treatment being studied.
Practical-significance. Whether the results are worth acting on – is entirely different. A six-month study of a weight loss pill might show statistically significant weight loss of only one pound, which isn't practically significant for someone who needs to lose 30 pounds. Source: Medical Economics 8/17/07; Riner Group. **Page 11**





Mediscene Newsletter

Volume 29 Issue 1

OUR FOCUS

May 2008

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 Heal 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

To request specific information regarding the Riner Group, or subscribe to our newsletter, please email us at requestinfo@rinergroup.com

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