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RECESSION TAKES ITS TOLL ON JOB HUNTING

The economy has had an effect on physician turnover and physician recruitment. Physician turnover dipped to 6.1% in 2008 from a high of 6.7% in 2006, according to a "2008 Physician Retention Survey" released by Cjecka Search. There has been a significant decline in the number of candidates applying for positions and the retirement horizon for a large number of physicians has also been extended.

WHO'S IN DEMAND

	2008-09	2007-08	2006-07	2005-06
Anesthesiologists	48	52	46	70
Cardiologists	103	69	163	174
Family physicians	595	492	303	257
Gastroenterologists	78	68	78	105
Internists	391	314	273	274
OB/GYNs	137	159	159	111
Orthopedic surgeons	147	145	172	207
Pediatricians	93	72	63	41
Radiologists	74	109	187	237

Source: "2009 Review of Physician and CRNA Recruiting Incentives," Merritt Hawkins & Associates
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THE WEIGHT OF EDUCATIONAL DEBT

The cost of private medical school education has risen 165%, and the cost of a public medical school education has gone up 312% in the last 20 years. In 2006, medical students graduated with an average of \$120,000 (public school) and \$160,000 (private school) in student loan debt. If eligible, most medical students defer loan repayment to complete their three-year residency. At the end of residency, the \$120,000 debt will have grown to \$151,342, and the \$160,000 debt will have grown to \$205,707. The chart shows how long it will take to pay off that student loan debt over the default period of 10 years or the extended repayment option of 25 years – raising a question in many people's mind, if you view it strictly financially, about the return on that investment.

DEBT FOR DECADES

Comparison of Federal Student Loan Repayment Plans*		
	2006 Avg. Grad Debt*	Amount After Deferment
Public School	\$120,000	\$151,342
Private School	\$160,000	\$205,707
	Monthly Payment 10-Year Services	Total Payments 10 Years
Public School	\$1,718	\$209,000
Private School	\$2,336	\$284,000
	Monthly Payment 25-Year service	Total Payments 25 Years
Public School	\$1,022	\$335,000
Private School	\$1,389	\$429,000

*Based on Stafford loan term of repayment at 6.8% APR

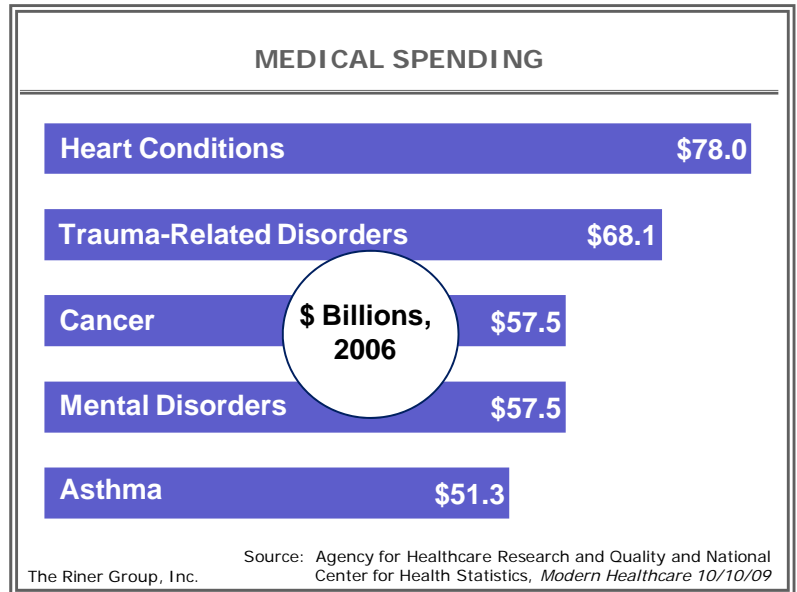
Sources: American Medical Association, Association of American Medical Colleges, *The Hospitalist*, July 2009

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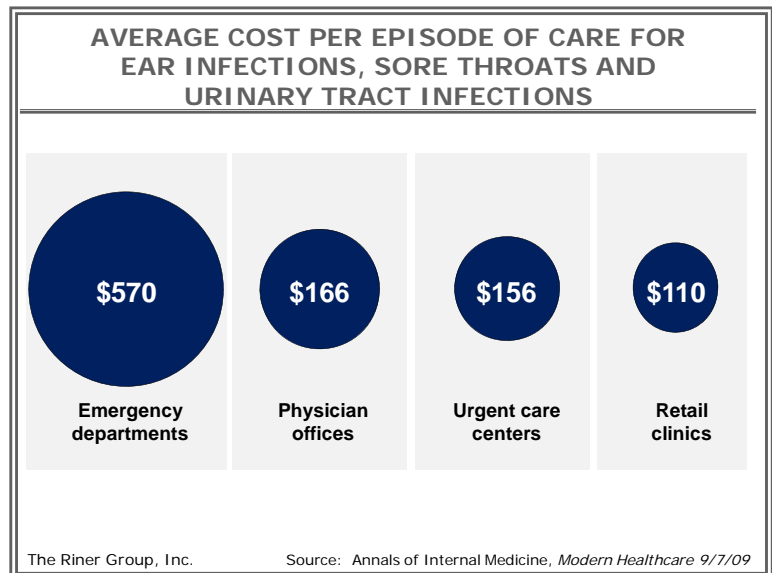
WHERE'S THE ACTION?

Heart conditions, trauma-related disorders, cancer, mental disorders and asthma were the five most costly conditions in terms of direct medical spending in 2006, according to a new analysis by the Agency for Healthcare Research and Quality.

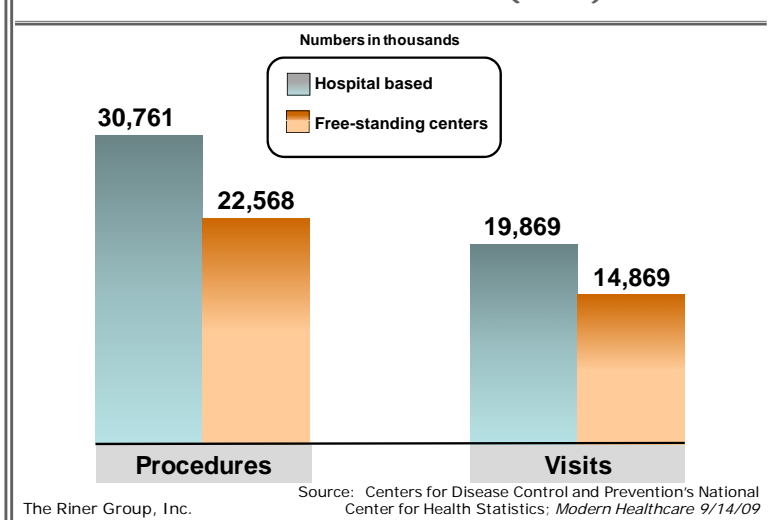


WHERE DO PATIENTS GO? / WHAT DOES IT COST?

Retail clinics provide care at a cheaper cost than other settings at comparable quality levels, according to a new study of insurance claims data published in the *Annals of Internal Medicine*.



AMBUATORY SURGERY (2006)

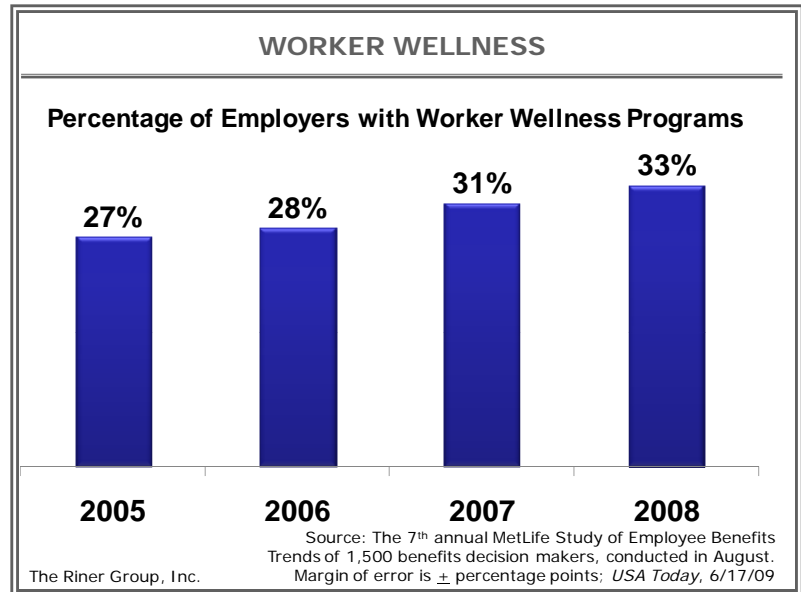


Hospitals perform more ambulatory surgeries than free-standing surgery centers, according to recently revised data from the Centers for Disease Control and Prevention.



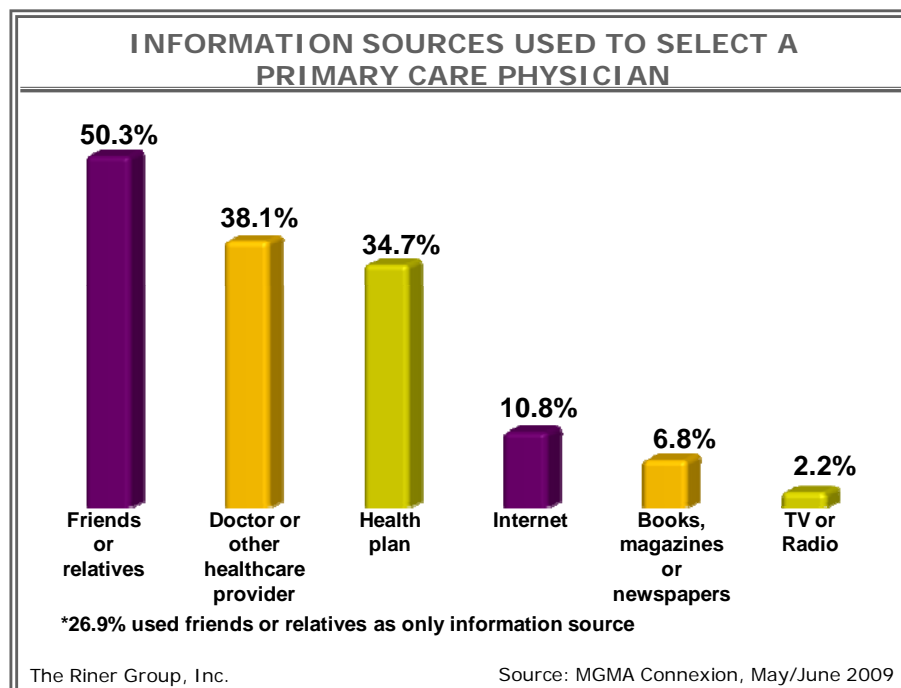
WELLNESS MOVEMENT IS ALIVE AND WELL

Despite the fact that there has been some proof that wellness programs work, companies desperate to slice expenses from their budgets during this recession are increasingly targeting workplace wellness programs. The problem is that it can take years to analyze the impact of these programs, and even then the return on the investment isn't always clear. Nonetheless, faced with the uncertainty of what shape the healthcare overhaul will take, and with healthcare expenses rising more than 6% a year, some companies aren't willing to completely abandon wellness. Slightly more than 60% of companies with 10,000 or more employees said they had wellness programs in 2008, up from 47% in 2005, according to the MetLife survey. In 2008, the median healthcare costs per employee was \$7,173, according to a survey by human resources consultants Watson Wyatt and employer coalition National Business Group on Health.



DOCTOR SHOPPING

Information sources are continuously used to select primary care physicians. The graph shows some of the most relied upon sources for information when selecting a primary care physician. Of note is the fact that the internet is still not as significant as friends and relatives.





Mediscene Newsletter

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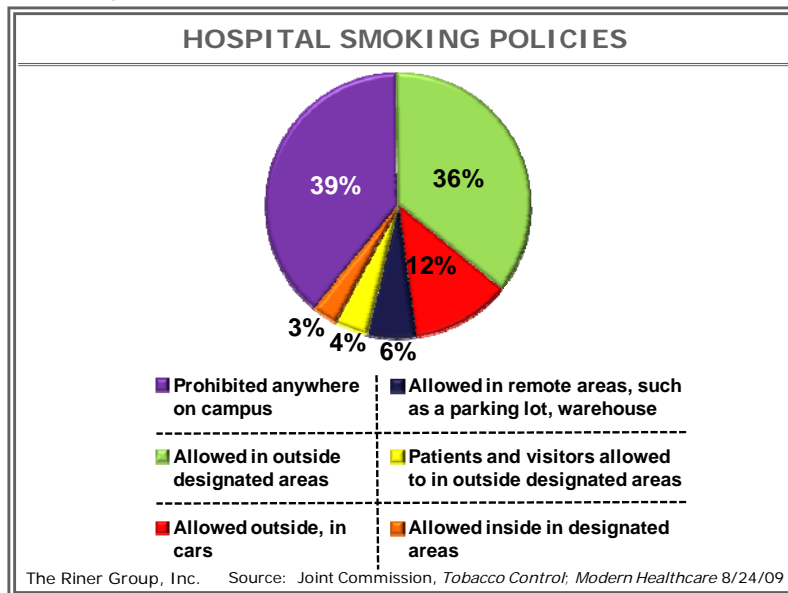


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WHAT'S TAKING SO LONG?

In an era where we are talking about healthcare costs and focusing on healthcare expenses, it is of interest that only 39% of hospitals had adopted a complete ban on smoking as of February 2008, according to a new study published online in the British journal, *Tobacco Control*.



WHO CAN YOU TRUST?

It is of interest that nearly two-thirds of adults take dietary supplements – a broad category that includes vitamins, minerals and herbal products – according to the Council for Responsible Nutrition, an industry trade group. The most commonly used include multi-vitamins, calcium and Omega-3. Most supplements are consumed without raising safety concerns. Still, the products are much less closely scrutinized than drugs which are tested extensively and must win FDA approval before they go on the market. Supplements made from products that were on the U.S. market before 1994 – as most commonplace supplements are – can be sold without being reviewed by the FDA beforehand. It might be prudent to research dietary supplements before consuming them.

SOURCES FOR RESEARCHING REMEDIES

Researching Remedies

- Sources on herbs and vitamins**
 National Library of Medicine's Medicine Plus
 Medlineplus.gov, under Drugs & Supplements,
<http://www.nlm.nih.gov/medlineplus/druginformation.html>
- National Center for Complementary and Alternative Medicine
<http://nccam.nih.gov>
- Office of Dietary Supplements
<http://dietarysupplements.info.nih.gov>
- The Centers for Disease Control and Prevention
<http://www.cdc.gov/nutrition/everyone/basics/vitamins/>
- Sources on specific products**
 You can start with the FDA's site, at www.fda.gov.
 Certification services can provide some outside verification that a product is safe. Here are their websites:
www.usp.org
www.nsf.org
www.informed-choice.org
www.ConsumerLab.com

The Riner Group, Inc. Source: *Wall Street Journal*, 9/8/09



DID YOU KNOW?

- Drug-eluting stent use declined more than 30% between 2006 and 2008. Patterns of drug-eluting stent use changed after a public debate related to scientific publications and presentations on their safety.

The researchers examined temporal patterns of drug-eluting stent use in 54,662 patients with non-STEMI who were enrolled in the CRUSADE and ACTION-GWTG registries. Among those, 27,329 underwent percutaneous coronary intervention from 2006 to 2008. The number of hospitals that participated in either registry varied between 171 and 208, with 125 hospitals participating in both registries.

The researchers observed a decline in drug-eluting stent use during the fourth quarter of 2006 that continued throughout 2007 and into the first quarter of 2008. Drug-eluting stent use in the 125 hospitals participating in both registries decreased steadily from around 90% in the third quarter of 2006 to 59% by the first quarter of 2008. Concurrently, the use of bare metal stents increased from around 10% in the third quarter of 2006 to slightly more than 40% in the first quarter of 2008. Source: Roe MT. Circulation: Cardiovascular Quality and Outcomes, 2009; doi:10.1161/CIRCOUTCOMES.109.850-248

- The Department of Health and Human Services (HHS) had proposed to adopt the ICD-10 Code set to replace the ICD-9 Code set for diagnosis and procedures by October 2011. In response to strident objections from physicians and payors pushing back against the ambitious timeframe for ICD-10 implementation offered by HHS, the department extended its deadline to October 2013. Professional associations are warning healthcare providers to formulate their ICD-10 plans to begin this implementation earlier than the deadline. The stakes are high for practices that serve Medicare beneficiaries. HHS has declared it will only reimburse claims with ICD-10 Codes after the 2013 deadline. From a diagnostic perspective the HHS proposal makes sense and appears to be prudent. ICD-10 has space for more than 155,000 codes, which allow for more specificity and detail than the currently employed ICD-9, which is limited to 17,000 codes. Nonetheless, two advisory groups – The North Carolina Health Information and Communications Alliance and the Workgroup for Electronic Data Interchange – estimate that ICD-10 implementation will take 966 days. For facilities desiring to meet a federally mandated compliance deadline of October 1, 2013, work on ICD-10 conversion should begin no later than January 18, 2010.
- Administrative Overhead – Just as hospital facilities are dealing with more administrative overhead, so are physicians and their practices. Recent studies have indicated that physicians divert as much as 14% of their gross revenue to assure accurate payments. The American Medical Association continues to rate large health plans plus Medicare in their promptness and accuracy for paying claims. The survey found a wide variation in practices among payors, with each using a different set of rules, different timelines, and confusing and inconsistent processes. Currently, doctors spend a total of three weeks a year, sometimes as much as 35 – 40 minutes a day trying to figure out which codes to use and which insurance plans cover at a cost of, some estimate, \$200 billion a year. In the report, AMA compared Aetna, Anthem Blue Cross Blue Shield, Cigna, Coventry, Health Net, Humana, UnitedHealthcare and Medicare in 18 measures from various points in 2008 and 2009. Ideally, one would think all these processes could be simplified. Hopefully, some of our healthcare reform will take a pragmatic approach to these issues.



DID YOU KNOW?

- Marginal Improvement – Ever since the Institute of Medicine published a report on the poor state of healthcare quality in the U.S. there have been many attempts to improve and stimulate the quality and cost effectiveness of our healthcare system. In that setting, many have embraced pay-for-performance programs. Since 2003, the Integrated Healthcare Association of California has operated the largest U.S. pay-for-performance experiment. The program targets 225 capitated integrated medical groups and independent practice associations, which contract with the seven largest HMO plans in California. The physician organizations represent approximately 35,000 physicians who care for more than 6.2 million patients enrolled in commercial HMO and point-of-service plans. Between 2003 and 2007, the participating health plans paid \$203 million in incentives to participating physician groups. The following were the findings.
 - ❖ Physician organizations believe that pay-for-performance has focused their organizational improvement efforts by increasing physician attention on quality, enhancing leadership discussion of how to improve quality, as well as improving data on which to base quality discussions.
 - ❖ Despite improved organizational support, many physician organizations reported constraints to improving quality, including inadequate information technology systems, such as the lack of an electronic health record as well as data issues and lack of data integration or missing data.
 - ❖ The majority of physician organizations felt that the benefits of focusing on quality probably outweighed the costs.
 - ❖ Physician organizations believed that common measure sets and bonus incentives were important motivators in the process. However, even though they felt that public reporting created a positive competitive incentive, they did not believe that consumers based their utilization decisions on that information.
 - ❖ Although physician organizations had responded to pay-for-performance, these changes had not led to adequate improvements in quality in the view of health plans. Indeed, many of the health plans wondered if the investments had actually improved quality or only improved data capture.

Most people are now looking at this issue of pay-for-performance as a small fix rather than a large panacea. Economic incentives alone will not improve or bring about the cost effectiveness that many are reaching for and desiring. Unfortunately in dealing with human beings is a complex matter unlike manufacturing, which deals with rigid performance characteristics of objects. Stay tuned for more research referable to this matter.



DID YOU KNOW?

- A 2008 report by the Medicare Payment Advisory Commission, a Congressional advisory group, estimated that eliminating unneeded hospital readmissions for heart failure could potentially save \$900 million annually, based on data from 2005. As hospitals and delivery systems move to potential bundling for congestive heart failure, a readmission within 30 days may not be reimbursable. To that effect, the American College of Cardiology has targeted heart failure readmissions. The college has announced the H2H Program. (www.acc.org/H2H/Enrollment), an educational initiative in collaboration with the Institute for Healthcare Improvement. However payment bundling is easily spoken of, but much more difficult to undertake in a nonintegrated healthcare delivery community.

PREVENTABLE HOSPITAL READMISSIONS AMONG MEDICARE BENEFICIARIES		
Initial condition/procedure	Number of potentially preventable 30-day readmissions	Total cost of preventable readmissions
Heart failure	139,000	\$903 million
Pneumonia	86,000	\$577 million
Chronic obstructive pulmonary disease	85,000	\$552 million
Percutaneous transluminal coronary angioplasty	68,000	\$569 million
Acute myocardial infarction	31,000	\$199 million
Coronary artery bypass grafting	27,000	\$215 million

Note: Analysis of 2005 Medicare discharge claims data using 3M software

Source: Medicare Payment Advisory Commission; *Cardiology News*, 5/2009

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- Hospitalists – A branch of internal medicine that has become one of healthcare’s fastest growing and most in-demand specialties will now be getting recognition as a separate Board Certification.

A five-year pilot program to test a plan for recertifying Internists as practitioners of hospital medicine (rather than general internal medicine) will be launched next year. The program called Recognition of Focused Practice, will be used by hospitalists who are completing their American Board of Internal Medicine 10-year maintenance of certification requirements.

The 9,000-member society of Hospital Medicine (founded in January 1997 as the National Association of Inpatient physicians) reports that about 82% of hospitalists are trained in general internal medicine.

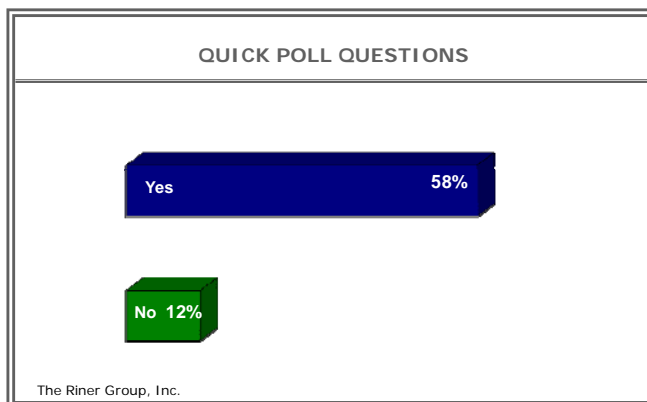
- A recent survey of 166 recruiters at hospitals and physician groups found that most rely heavily on internet postings, as well as word-of-mouth, to locate physicians for open positions. They were using physician search firms less than other tools, citing both the costs and complaints that firms did not gather up enough qualified candidates. 55% of in-house physician recruiters used external firms in 2008; only 49% did in 2009, according to a survey of members of the Association of Staff Physician Recruiters, which was released September 1, 2009 and was conducted by the Medicus Firm.
- Finally, a study entitled “United States Emergency Department Performance on Wait Time and Length of Visit” found that a mere 30% of Emergency Departments got the majority of their patients seen by a physician within recommended time frames, and only 13.8% of the Emergency Departments achieved the triage target for the majority of patients who needed to see a doctor within one hour. These figures were released by the National Quality Forum (NQF) which has been looking at changes in Emergency Department quality standards, including measures on wait times and visit length for admitted patients. Though NQF has not defined a target length of visit in the United States, the United Kingdom defines it as four hours. Canada suggests four to six hours, and Australia says eight hours.



OUR QUICK POLL RESULTS

The following question was posted on the Riner Group Website for the months May – October 2009.

“ Do you feel there will be need for a middle class tax hike given the healthcare reform discussions as currently formulated?”



Perspective: We certainly are not economic specialists. However, it would appear that the hard truth is that there will definitely be necessity for a tax increase at a level much broader than what the President has been proposing. In a recent paper entitled **“Taking Back Our Fiscal Future”** (written by 16 Republican and Democratic fiscal experts and published by both the Brookings Institution and the Heritage Foundation in April of 2008) one of the authors, C. Eugene Steuerle, states “Government has a balance sheet and everything it does must be paid for.” The very wealthy alone cannot close the budget gap, according to the provocative paper. The healthcare plan alone will add about \$1 trillion over 10 years to our \$1 trillion deficit. Experts suggest that taxing the rich would raise an extra \$615 billion over 10 years. The report says even raising revenues as a percent of gross domestic product to European levels – levels that are unprecedented in the United States – will not be sufficient. Social Security and Medicare costs are expected to add another \$6.6 trillion to the deficit by 2026, according to the Congressional Budget Office.

For this reason, the middle class, which receives most of the government’s benefits, will have to be part of the fiscal solution. The panel’s view is that Congress will need to address Social Security, Medicare, Medicaid and various tax subsidies for the rich by making such programs adhere to strict budgetary constraints. A more drastic solution is being proposed: Subsidizing healthcare only for the poor, while everybody else would pay out-of-pocket for routine care and insure only for catastrophic medical events. (Isn’t that what insurance is for anyway?)

One of the other interesting concerns is stated: “We are particularly worried that automatic growth in programs directed primarily at seniors will crowd out growth-enhancing investments in the skills and well being of the young.”

In summary, according to this panel and the panelists participating in this economic analysis: Taxing the rich alone will not be the solution, eliminating waste in government programs won’t save us, and it’s unrealistic to think we can grow our way out of a budgetary mess. The price tag for current and future health and welfare programs is extremely steep. The plain truth is that it is going to be extremely difficult for the Federal Government to keep all of its promises unless major modification and attention to budgets is undertaken.

Source: *Brookings Institution and Heritage Foundation, April 2008; Barron’s, August 10, 2009*



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SPEAKING ENGAGEMENTS

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

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

THE RINER GROUP HAS RECENTLY PUBLISHED TWO ARTICLES

"Physician Hospital Alignment: Finding the Sweet Spot"
published in the September 2009 issue of *Journal Of Invasive Cardiology*

"Getting Ready for EHR, RHIOs & Next General Co-Management Agreements"
published in the November/December 2009 issue of *The Physician Executive*.

View a list of Riner Group published articles on our website
www.rinergroup.com/resources/articles

Watch for upcoming articles on Concierge Medicine and Referral Science

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.

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



Happy Thanksgiving



*Joy, Happiness, Health
All of these and many more are wishes
for you from The Riner Group*