



STRATEGY AND ADAPTABILITY IN A COMPETITIVE MARKET: LESSONS FROM THE NATION'S LARGEST ANESTHESIA ORGANIZATIONS

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As of April 1, 2017, eight entities employed more than 22 percent of all anesthesia providers in the United States. The size and scope of these entities could not have been envisioned just a decade ago. How each of these organizations grew or morphed to its current size and scope reflects the dramatic changes reshaping hospital-based physician practices and the specialty of anesthesia. More relevant still is what the history and evolution of these organizations tells us about the future of the market for anesthesia services and what threats and opportunities lay ahead for the typical hospital-based anesthesia group.

Traditionally, an anesthesia group was an entity owned by anesthesia providers intent on maintaining and managing a



specific niche that might include one or more hospitals and various surgery centers or doctors' offices in a given local market. Although they represented a variety of legal entities, corporations, partnerships

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BUILDING A SOLID AND SECURE FUTURE IN ANESTHESIA

One look at a graph showing completed acquisitions of anesthesiology and pain practices over the past several years reveals an upward slope and a clear illustration of a marked trend within the specialty. Acquisitions have grown steadily, from three in 2009 to 37 in 2016. According to one source, anesthesia and pain practice acquisitions increased at a seven-year compound annual growth rate of 43 percent.

The trend does not appear to be slowing. Despite the number of transactions during this time, the larger national anesthesia companies indicate they still have substantial room for growth throughout much of the United States. While most of the acquisitions have taken place in the East, the large companies are looking to expand geographically in other parts of the country.¹

This relatively recent national movement in anesthesia toward consolidation presents individual practitioners and groups with a complex set of questions as they consider their futures. Is selling to a large national company inescapable in an increasingly competitive marketplace? What are the options?

Our lead article, co-authored by Howard Greenfield, MD of Enhance Healthcare Consulting, and Jody Locke of Anesthesia Business Consultants, provides historical context and guidance. What can hospital-based practices learn from the national companies? Is becoming part of a large company the only way to remain viable, or can practices glean lessons from these big players and position themselves more competitively by adapting some tried and true approaches?

“To the extent that most anesthesia groups have existed to optimize collec-

tions and shareholder compensation, they have not been willing to make the kinds of investment in infrastructure and leadership necessary to facilitate growth and the development of new business lines,” contend Dr. Greenfield and Mr. Locke. The authors explore related issues, including the role of practice size and the importance of developing and fine-tuning a corporate strategy, “often the distinguishing feature between these large organizations and typical hospital practices.”

In a similar vein, regular contributor Will Latham of Latham Consulting Group offers perspective on the full range of options in *Where Do We Go From Here? Choosing the Right Path in Turbulent Times*. Mr. Latham considers the pros and cons of the spectrum of choices, including merging, hospital employment and selling. Like Dr. Greenfield and Mr. Locke, Mr. Latham extolls the necessity of strategic planning.

Regardless of where an anesthesia group chooses to go, building relationships with facilities remains an essential ingredient of security and success. Once primarily a way for hospitals to “shake things up,” often without actually making a change in anesthesia providers, the request for proposal (RFP) has come to signify a serious interest in evaluating whether another group might deliver greater value. Robert Johnson, MBA and Robert Stiefel, MD of Enhance Healthcare Consulting discuss the factors that motivate hospitals to issue an RFP and the signs that an RFP may be coming.

Mark F. Weiss, JD returns to this issue with advice for anesthesiologists on preserving hospital relationships and job security in light of the high CEO turn-

over rate. “Even if you’ve done everything right, you can’t be certain that the new CEO won’t disrupt the relationship,” he writes. An American College of Healthcare Executives survey showing a 2016 turnover rate of 18 percent among hospital CEOs underscores the need to have contractual promises from the current CEO in writing. Trust, but verify.

Lastly, Neda M. Ryan, Esq. zeroes in on an even more pressing type of security, i.e., the need to prepare for and protect against a ransomware attack, a serious and growing healthcare threat that could potentially put lives at risk. Ms. Ryan outlines steps to take if a ransomware attack occurs and how to protect your practice and meet the requirements of the Healthcare Insurance Portability and Accountability Act (HIPAA) related to electronic protected health information.

We’re looking forward to ANESTHESIOLOGY® 2017 in Boston, October 21-25 and hope to see many of you there. Enjoy the rest of your summer.

With best wishes,

Tony Mira
President and CEO



¹Haverford Healthcare Advisors, Anesthesiology Practice Acquisitions, January 2017. <http://www.haverfordhealthcare.com/wp-content/uploads/2016/10/Anesthesiology-Practice-Acquisitions-January-2017.pdf>



ARE YOU PREPARED FOR A RANSOMWARE ATTACK?

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Imagine seeing the following message flash onto your computer screen: “Many of your documents, photos, videos, databases and other files are no longer accessible because they have been encrypted.” What would you do?

That is the message computer users in more than 150 countries throughout the world saw on May 12, 2017 when their computers became infected with WannaCry, a ransomware program. The attack left several businesses, including many health organizations, scrambling to protect their data.

Although the number of WannaCry attacks in the United States was limited, this should be a reminder to all, especially healthcare organizations, to be prepared. The attack highlights the importance of complying with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requirements, which promote security of protected health information, and prudent computer and internet use.

RANSOMWARE DEFINED

Ransomware is a type of malicious software used by hackers to encrypt the user's data and deny access to it until the user pays a ransom, usually in the form of a cryptocurrency like bitcoin. Hackers can also deploy ransomware that will destroy data.

In the case of the WannaCry virus, hackers exploited a known Microsoft Windows vulnerability and infected computers that did not have a security patch designed to fix the issue. The hackers



encrypted the data and demanded \$300 in bitcoin in order for it to be decrypted. By the second day, the amount went up to \$600. After seven days, the data would be deleted.

Unfortunately, this is becoming a fairly common occurrence. According to a U.S. government interagency report, an average of 4,000 ransomware attacks occurred per day in the U.S. since early 2016. This marks a 300 percent increase from the 1,000 daily attacks reported in 2015.¹

HIPAA SECURITY RULE

Healthcare organizations are already required to follow HIPAA, which guards against the unauthorized access of electronic protected health information (ePHI). Specifically, the Security Rule establishes minimum technical, administrative and physical requirements that entities must follow in order to protect ePHI.

Requirements include implementing a security management process to identify threats and vulnerabilities to

ePHI, mitigating the identified risks, and creating procedures to guard against and detect malicious software.

One of the security management processes is a risk analysis. This type of analysis is the foundational element and first step in identifying and implementing safeguards required by the Security Rule. Methods vary depending on the entity's size, complexity and capabilities.

Information from the National Institute of Standards and Technology (NIST) details factors that entities should consider in designing a risk analysis. Factors to consider include identifying sources of ePHI—both within the organization and outside of it. Also, the plan should consider the human, natural and environmental threats to ePHI.

To assist in these endeavors, the Department of Health and Human Services Office of the National Coordinator for Health Information Technology (HHS ONC) has developed an online Security Risk Assessment Tool: <https://www.healthit.gov/providers-professionals/security-risk-assessment-tool>. Results from the risk analysis can be used to create policies for personnel screening; determine what data to back up; determine whether and how to use encryption; address what data must be authenticated to protect its integrity; and determine the appropriate manner of protecting ePHI transmissions.

DATA BACKUP PLAN

HIPAA also requires entities to create a data backup plan as part of an overall contingency plan to protect ePHI.

¹ <https://www.justice.gov/criminal-ccips/file/872771/download>



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and LLCs, they were fundamentally professional fraternal organizations designed to perpetuate a certain status quo. They operated with very lean overheads. The cost of malpractice insurance and billing were the largest expenses.

While most anesthesia groups today have exclusive contracts with the facilities they serve, the legal constraints of such agreements are considered little more than a necessary evil. The primary objective of most anesthesia practices is job security and maintenance of the owners' income and lifestyle. It is safe to say that most of the thousands of anesthesia practices across the country have not aspired to be anything more than good partners with the facilities they serve by providing consistent patient care.

THE COMPLEXITIES OF GROWTH

Growth is not something that most practices have embraced willingly. But it has become a market reality that cannot be denied. As managed care became a critical factor in healthcare economics, most hospitals insisted that the anesthesia department function as one integrated entity rather than as multiple independent practices. This change resulted in hundreds of anesthesia group formations—some amicable, others not. Such shotgun marriages often resulted in dysfunctional entities with conflicting cultures and values. Some entities took the opportunity to develop regional mergers and partnerships. In retrospect, these were the exceptions rather than the norm. Perhaps the best example is Mountain West Anesthesia, LLC in Salt Lake City. At one point, LDS Hospital in Salt Lake City had 35 independent anesthesiologists. The administration asked them to form one group. They agreed to merge but not only at that facility. They



incorporated virtually all of the anesthesiologists along an area of Salt Lake City known as the Wasatch Front, producing an organization that now includes 150 board certified anesthesiologists.

More often than not, though, the selection of a common billing solution and disagreement over new group leadership and governance structure ultimately prove insurmountable to the completion of the merger. Many merger discussions end inconclusively and a viable entity is never created.

ANESTHESIA'S ALLURE

The past two decades have seen a tectonic shift in the anesthesia market across the country. The entities profiled below represent those that, for the time being, appear to have successfully positioned themselves in the new market. While a few of these entities are still single-specialty practices owned by the practice's physician partners, the majority have been sold to groups of investors clearly intent on mining the specialty's profit potential.

Savvy and successful investors expect two things: growth of the core business and

a significant return on their investment. One may wonder why anesthesia has earned such investor interest. The reality is that significant amounts of capital are being channeled into many of these organizations. Some, like Somnia and NorthStar, have developed aggressive marketing programs and a national salesforce to identify and reach out to new hospital clients. Others, such as MEDNAX and U.S. Anesthesia Partners (USAP), employ a merger and acquisition strategy aimed directly at large- and medium-sized anesthesia groups in a specific region. Large multispecialty organizations such as TeamHealth and Sheridan (now Envision) grow their anesthesia footprint by providing the intended client with additional hospital-based services in such areas as neonatology, emergency medicine and radiology.

For years, Envision and TeamHealth have responded to requests for proposals (RFPs) from hospitals and health systems. This can be a time-consuming and frustrating process that requires the bidder to make sense of limited financial and often incorrect operational information to project potential revenue and develop an appropriate staffing model. The successful bidder must find ways to demonstrate their value to the prospective partner, generate a profit within the constraints of the hospital budget or reduce the present anesthesia subsidy. Many organizations have found this to be a slow and risky way to grow the business, given the fact that many of the institutions that generate RFPs are doing so because the previous group could not operate the department profitably due to low or inconsistent surgical volume and challenging payer mixes.

This explains the current interest in acquisitions of profitable anesthesia practices. The capital requirements are far

greater, but the results are considerably more predictable. By acquiring Valley Anesthesiology Consultants in Phoenix, for example, Envision expected to count on a large, stable and well-run organization to enhance its balance sheet. As most of these organizations prove the value of such acquisitions, they enhance their ability to raise additional capital from potential investors. The amount of private equity money and new investors interested in the anesthesia market seems limitless.

REINVENTING THE SPECIALTY

The evolution of the specialty from fraternal organizations to strategic and profit-driven business entities has the potential not only to affect all anesthesia groups, irrespective of size and location, but also to redefine how anesthesia services are provided in an environment where the ability to safely manage a patient through the discomfort and trauma of surgery is now considered a commodity.

The American anesthesia market used to be viewed through the lens of regional interests, conventions and state-specific regulations. Nurse anesthetists and anesthesia care teams were common in the South and East, but rarely used in the West. Anesthesia practices in the Mid-Atlantic region aggressively sought opportunities to provide anesthesia to endoscopists and endoscopy centers, while those in the West, specifically in California, were reluctant to take on such services.

Anesthesiologists in the East tend to have compensation systems based on a salary and bonus structure, while those in the Chicago area and California tend to have complicated compensation formulas and “eat what you kill” models. Even the concept of the need to form group practices emerged very differently across the country. The anesthesia practice at Cedars Sinai in Beverly Hills, for example, was



not formed until 1994, well after many of today's largest Eastern practices had been formed.

Many of the largest entities profiled here have adopted national strategies. In addition, anesthesia management groups such as Premier Anesthesia and ApolloMD also provide anesthesia services to hospitals and ambulatory surgery centers (ASCs) in multiple states. They will talk to any hospital administration, health system or anesthesia practice if there is potential interest. About five years ago, Somnia, which had no contracts in California, a state considered averse to the use of CRNAs, secured a contract at the Kern County Medical Center by introducing the concept of the anesthesia care team to a hospital that had historically used physician-only anesthesia. The model worked. The organization now has additional contracts in California and one in Washington State utilizing the care team model.

American healthcare is in a state of reinvention and the transformation will impact every anesthesia practice. The very vocabulary of anesthesia practice management has changed. Customer service is no longer optional but an essential requirement for each anesthesia

group's survival and success. Quality is no longer a subject of anecdotal evidence but a statistical discipline, reported regularly to the hospital. It used to be said that the worldview of an anesthesiologist was defined by the four walls of the operating room, and that all they were concerned about was managing each case. Now, what happens outside the OR is far more significant than the anesthesia practice's security and success.

Consistent results and quality care are a given. If you are not actively engaged in and closely aligned with the hospital's business plan and strategy, you are bound to become incidental and obsolete. That is why the large organizations such as Team-Health and Envision focus on forming partnerships and joint ventures with hospitals and healthcare systems, and not just obtaining single specialty contracts. Their goal is to be indispensable to the facility's or system's growth.

PROFILES IN EXPANSION

What are some of today's most successful anesthesia entities and how big have they become? The following representative, but not necessarily

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comprehensive, sample shows the relative size of these organizations. (The numbers of physicians and CRNAs are based on information compiled from a variety of sources over the past few months. Given the industry's dynamic nature, any of these numbers may change by the time this newsletter is published. See Table 1.)

1. **Envision Healthcare:** Envision Healthcare is the new name for the merger of AmSurg (Sheridan) and EmCare that occurred in 2016.

Sheridan began in 1953 as Anesthesia Associates of Hollywood at Memorial Hospital in Hollywood, FL. The partners sold this practice in 1992 to a private equity firm and Sheridan Healthcare was created. Sheridan grew its practice organically and through acquisitions and ventured into emergency medicine, neonatology and radiology service lines over the next 20 years with capital from four different pri-

vate equity partners. Sheridan was acquired by AmSurg, a nationally recognized leader in the development, management and operation of outpatient surgery centers, in May 2014. AmSurg merged with EmCare Anesthesia in 2016 to create Envision Healthcare.

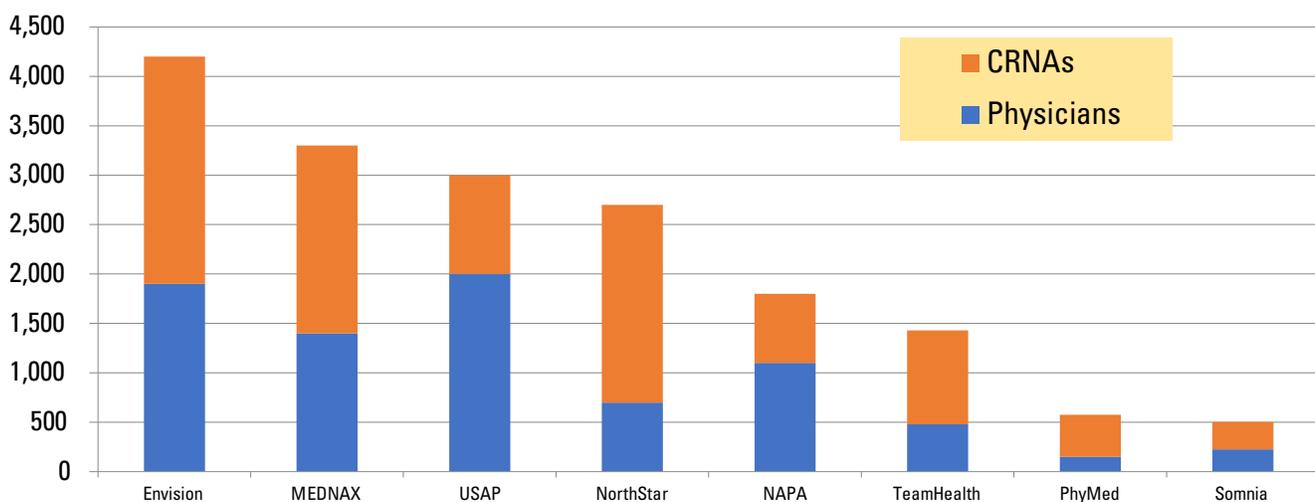
2. **EmCare:** EmCare Anesthesia was founded in Dallas in 1972 and initially grew by providing emergency department staffing and related management services to larger hospitals in the Texas marketplace. EmCare expanded its presence in emergency department staffing nationally, primarily through a series of acquisitions in the 1990s. In 2005, EmCare merged with AMR, the largest provider of ambulance transport services in the U.S., and EmCare expanded into the anesthesiology service line in late 2008. EmCare was a large national provider of physician

practice management services for emergency departments, inpatient physician services or hospitals, acute care surgery, trauma and general surgery, women's and children's services, radiology/teleradiology programs and anesthesiology services prior to its 2016 merger with AmSurg.

3. **MEDNAX:** MEDNAX was originally called Pediatrix and also originated (in 1979) at Memorial Hospital in Hollywood, FL. The hospital's neonatology group expanded exponentially across the U.S. by mergers with and acquisitions of numerous neonatology groups in the private and academic sectors. In 2007, they entered anesthesia with the purchase of Fairfax Anesthesia under the American Anesthesia division. In 2009, they expanded their children's service division to include pediatric intensivists and hospital-

TABLE 1

Largest Anesthesia Entities (April 2017)





ists. In 2014, MEDNAX acquired Surgical Directions, a specialty healthcare consulting firm. In 2015, they expanded into radiology with their \$500 million acquisition of vRad, a large tele-radiology platform.

4. **USAP:** USAP was formed with backing from the private equity firm Welsh, Carson, Anderson & Stowe, one of the early investors in Sheridan. They put together a team of former executives from MEDNAX and Sound Physicians and entered the anesthesia market in 2012 by acquiring Greater Houston Anesthesiology and Pinnacle Anesthesia in Dallas. They have expanded in Texas and beyond, and now have physician partners in large anesthesia groups in Denver and Orlando. USAP acquired Anesthesiology Consultants, Inc. (ACI) in Las Vegas in 2016 and Physicians Anesthesia Service (PAS), a 120-plus provider group in Seattle, in February 2017.
5. **NorthStar:** NorthStar was founded in 2006 by an anesthesiologist and CRNA in the Dallas area. They have expanded primarily through organic growth by winning RFPs with a CRNA-centric anesthesia care team model. NorthStar was acquired by private equity giant TPG in 2013 and has increased its merger and acquisition activity, paying particular attention to the Midwest. They acquired AmSol in 2014, Detroit-based Anesthesia Staffing Consultants in 2015 and Chicago-based Continental Anesthesia in 2016.
6. **NAPA:** NAPA was formed in 1982 at North Shore University Hospital in Manhasset, NY by 25 anesthesiologists who have all been independent practitioners.



The practice grew with the addition of CRNAs. Then North Shore Hospital merged with Long Island Jewish (LIJ) Hospital and other Long Island hospitals. Group leadership convinced administration that North Shore Anesthesia Associates should provide anesthesia services to all North Shore LIJ hospitals. The administration agreed and NAPA was formed. NAPA has remained a single specialty provider and has twice sold to private equity investors intent on seeing the organization continue to grow.

7. **TeamHealth:** TeamHealth began in 1979 as an emergency medicine practice in Knoxville, TN. They now have more than three decades of experience in physician services and have grown from a small company to one of the largest integrated care providers in the country. Today, 19,000+ clinicians offer staffing, administrative support and management across the full continuum of care, from hospital-based practices to postacute care and ambulatory centers. TeamHealth entered the anes-

thetia market in January 2010 with their acquisition of Anesthetix. In 2015, TeamHealth acquired IPC, a large hospitalist company. That same year, TeamHealth rejected a \$5 billion offer to be purchased by AmSurg. The company was taken private for the second time by the Blackstone Group in early 2017.

8. **PhyMed:** PhyMed began in Nashville in 1994 when two anesthesia groups merged to form Anesthesia Medical Group (AMG). They grew within the Tennessee market and became PhyMed when they were acquired by private equity firm Excellere Partners in 2012. In 2014, they were acquired by their present investor, The Ontario Teachers' Pension Fund. This infusion of equity helped them acquire practices in Pennsylvania and Maryland in 2015 and expand into pain management and critical care.
9. **Somnia:** Founded in New Rochelle, NY in 1996 by two anesthesiologists who own and operate this company today, Som-



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nia manages anesthesia services for hospitals, ASCs and office-based surgical practices in more than 13 states with more than 500 anesthesiologists and CRNAs. Somnia has expanded nationally in recent years and has introduced the anesthesia care team to a number of large West Coast facilities.

Table 2 provides some insight into the diversity of service lines that these entities now cover. It is significant that while all of these companies provide anesthesia services, some also provide other services to broaden their relationship with the facilities they serve.

STRATEGIC QUESTIONS

A review of the history, scope and current size of these entities raises a number of questions about the future of the specialty and how individual practices across the country need to position themselves to survive the inevitable market changes.

The first question is whether bigger

is necessarily better. Can these mega-entities really get paid more and do they really need less subsidy support? When one considers each organization's distinct strategies, one may conclude success is less about size and more about strategic plan and focus. Ultimately, as the average group practice looks in on these entities, the question one might ask is "What about the rest of us?" Is the battle already lost? Is absorption inevitable or does an understanding of what these organizations have achieved provide useful insight into a necessary set of survival skills that all practices must adopt?

The Value of Size: Consolidation, the wave of the present in healthcare, also appears to be the wave of the future. There are fewer payers today than 10 years ago. More and more hospitals are now part of large networks. It appears inevitable that anesthesia practices need to seek similar opportunities to maintain access to their facilities and exercise reasonable leverage in their negotiations with facilities and payers. The evidence shows that most of the largest anesthesia entities have

higher contract rates with payers than their smaller competitors. Many would also argue that they have achieved greater security by virtue of their size and scope.

How does an anesthesia practice become a mega-group? For years, anesthesia practices have been entertaining merger discussions with groups in their markets. Anesthesia Services Medical Group (ASM) in San Diego achieved its current size simply by consolidating the market in San Diego County. The story of Oregon Anesthesiology Group (OAG) in Portland was probably modeled to some extent after ASM. Growing to the size of an Envision, however, requires an entirely different strategy.

The question of growth also presents a fundamental cultural challenge. Most anesthesia practices are essentially professional associations with limited business or professional management. One cannot manage a practice of 100 or more providers the same way one manages a practice of 10 or 20. Until practices are willing to invest in professional management and accept the organizational and management requirements of a large organization, they will never make the transition.

Those who manage these large organizations have come to learn that size does not guarantee success. They have also come to appreciate that the goal is not just the ability to obtain higher rates from payers. Those who truly understand the dynamics of the current environment recognize that security and predictability are far more important than short-term financial gains.

The Value of Strategy: Size, therefore, is useful, but not necessarily a predictor of success. In a competitive environment, strategy ultimately distinguishes winners from losers. Many observers of today's environment would argue that it

TABLE 2 Service Lines in Large Anesthesia Companies

	Anesthesia	Emergency Department	Neonatology	Radiology	Hospitalists
Envision	X	X	X	X	X
MEDNAX	X		X	X	
USAP	X				
NorthStar	X				
NAPA	X				
TeamHealth	X	X	X	X	X
PhyMed	X				
Somnia	X				



is the ability to custom-tailor each service agreement to the unique and specific needs of the customer that is critical to long-term relationships. Consider IBM, with its corporate bureaucracy, which is fading into obscurity, while Apple continues to thrive. Each of the entities profiled here has formulated a strategic game plan that it believes will position it for growth and success. This did not happen by accident. Corporate goals and priorities must continuously be evaluated and refined to meet changing market conditions. This unceasing attention to goals and priorities is often the distinguishing feature between these large organizations and typical hospital practices.

Inevitably, finance drives strategic thinking. To the extent that most anesthesia groups historically have existed to optimize collections and shareholder compensation, they have not been willing to make the kinds of investment in infrastructure and leadership necessary to facilitate growth and the development of new business lines.

One of the most significant aspects of anesthesia's evolution in the U.S. is that it is no longer just a service limited to managing patients safely through surgery. Hospitals are looking for strategic partners. The anesthesia practice should have more and better data about what happens in the operating room and delivery suite, and must share what they learn with their hospital partners to prove their value. Today's anesthesia care team practices have enormous potential to help hospitals manage their operating room suites more effectively. Quality is no longer a matter of anecdotal conjecture, but must be empirical and measurable. While many anesthesia practices used to take their relationship with administration for granted, today's successful practices recognize that they must be willing to make a serious commitment to partnership and to become indispensable to the facility's strategic plan.

The Future of the Market: What does the future hold for the rest of anesthesia? Is it inevitable that all anesthesia providers will ultimately become employees of a small number of national organizations? How big can and will these organizations grow? These answers are unknown.

One thing we know for sure is that today's healthcare market is unpredictable. For the past seven years, healthcare providers have been assuming that the Affordable Care Act (ACA or "Obamacare") would provide market structure and anticipated the implementation of accountable care organizations. Now there is talk of an ACA repeal, but no one knows what form a replacement will take.

What we do know is that the cost of healthcare continues to rise and that the cost of care is a major political issue. The market will have to find more efficient and cost-effective ways to deliver needed care. Organizations with the best value propositions will inevitably prove the most successful. Size is not an essen-

tial prerequisite, but it clearly helps. The bigger the organization, the greater the resources and the broader the scope of services it can offer. Any organization that is not willing to invest in professional management and the development of the technology to enhance its quality and scope of services will inevitably lose out to those that do. ▲

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both hospitals and anesthesia providers. Throughout his career, he has worked with hospitals and providers to align incentives and develop cost-effective and timely solutions for OR management. In addition, he has expertise in optimizing anesthesia group and OR performance by working collaboratively with hospital administration, surgeons, OR nurses and anesthesiologists nationwide. He was a founding partner of Sheridan Healthcare and served as chief of anesthesia at Memorial Regional Hospital, Hollywood, FL. Dr. Greenfield received his training at Temple University School of Medicine and Jackson Memorial/University of Miami. He can be reached at hgreenfield@enhancehc.com or (954) 242-1296.

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ARE YOU PREPARED FOR A RANSOMWARE ATTACK?

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Requirements include a data backup plan that creates and maintains retrievable data and exact copies of ePHI. Also included is a disaster recovery plan for restoring any loss of data. Finally, an emergency mode operation plan details procedures to allow the continuation of critical business operations and protect ePHI while the system is in emergency mode.

In a fact sheet about ransomware attacks, HHS underscores the importance of maintaining frequent backups and ensuring the ability to recover data from those backups to effectively recover from a ransomware attack. According to HHS, “[t]est restorations should be periodically conducted to verify the integrity of backed up data and provide confidence in an organization’s data restoration capabilities. Because some ransomware variants have been known to remove or otherwise disrupt online backups, entities should consider maintaining backups offline and unavailable from their networks.”²

IF A RANSOMWARE ATTACK OCCURS

HIPAA requires entities to have detailed procedures in place to use when responding to an attack in order to get back to “business as usual.” The procedures should include ways to detect ransomware, how to conduct a risk analysis and ways to stop malware from spreading in the case of an attack. Post-incident activities should also include considering what, if any, type of notification is required by law, how the attack happened and if improvements need to be made in order to prevent it from happening again.

Employees should be educated on prudent computer and internet use. Employees should also be educated on

ways to detect and respond to ransomware. Employees should know how to tell if an attack is occurring and what to do after clicking on something they later deem suspicious.

HHS recommends the following steps if an organization is the victim of a ransomware attack:

- Contact your FBI National Cyber Investigative Task Force <https://www.fbi.gov/investigate/cyber/national-cyber-investigative-joint-task-force> immediately to report the event and request assistance. The task force will work with state and local law enforcement and other partners to pursue cybercriminals globally and assist the victims.
- Report cyber incidents to the US-CERT (United States Computer Emergency Readiness Team, <https://www.us-cert.gov>) and the FBI’s Internet Crime Complaint Center, <https://www.ic3.gov/default.aspx>.

Organizations should also immediately contact their attorneys. Notifications to individuals, HHS and, in some instances, the media, under HIPAA should be considered very thoughtfully and with the assistance of counsel. The question of whether a ransomware attack amounts to a HIPAA breach is one of industry debate. Iliana Peters, a HIPAA compliance and enforcement official at the Office of Civil Rights (OCR), announced at a Georgetown University Law Center cybersecurity conference that OCR will “presume a breach has occurred” when a HIPAA covered entity or business associate is the victim of a ransomware attack. However, industry experts argue that this theoretical position does not marry with how a ransomware attack works in actuality. Nevertheless, an overarching conclusion cannot be drawn without

considering the facts and circumstances of a particular attack or event. However, victims of ransomware attacks must be aware of this possibility and should consider this with their attorneys.

WAYS TO PROTECT YOUR PRACTICE

The risk of a ransomware attack targeting a healthcare organization, especially a smaller one, is great. Ransomware attackers know that healthcare organizations are notoriously unprepared for such attacks, making them prime targets. As such, anesthesia and pain practices should take care to conduct security risk assessments; fill in gaps, either through policy or technological improvements; adopt ransomware attack policies and educate their employees and staff on them; and purchase a cyber liability insurance policy to protect in the event a ransomware attack occurs. Now is the time to take action.

For the most current federal government information regarding ransomware attacks, go to www.us-cert.gov.

Note: The author extends special thanks to Amy Ryman, paralegal and executive administrative assistant at Anesthesia Business Consultants, for her contributions to this article. 

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² <https://www.hhs.gov/sites/default/files/RansomwareFactSheet.pdf>



WHERE DO WE GO FROM HERE? CHOOSING THE RIGHT PATH IN TURBULENT TIMES

Will Latham, MBA

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The environment continues to be a challenging one for anesthesia groups. Health systems are combining, stipends are under pressure and payment system changes loom. And there is always someone knocking at your hospital CEO's door saying they can do it better, faster and cheaper. So, what direction should anesthesia groups pursue at this time? In our recent work with several groups, the options appear to fall out as follows.

GO IT ALONE

After considering alternatives, some groups decide to go it alone, avoid growth and hunker down to focus on the hospital or health system they are currently serving.

Why are these groups making these decisions while the rest of healthcare is consolidating? They give several reasons:

- They see no long-term shareholder benefit from growth. They believe they will have to staff all new locations with shareholder-track physicians.
- Growing is painful. People may have to drive to new locations (gasp!) or work in other hospitals.
- Growth is a lot of trouble. Someone has to spend time to seek out new opportunities. No one is allocated time or paid to conduct such activities. Senior physicians in the group often see any changes as costing resources for which they will receive no benefit.



- They feel that their relationship with their current hospital is excellent and not likely to be threatened by outsiders (at least as long as their careers last).

This is the “eggs all in one basket” strategy, and a very risky one. For some groups in rural areas this may be the only alternative, although we see a number of regional mergers forming (discussed below).

ORGANIC GROWTH/NEW SERVICE LOCATIONS

More energetic groups are looking at taking over new service locations. These may be new service locations in their current hospital/health system, an ambulatory surgery center (ASC) or another hospital in their region.

The potential benefits of such expansion include:

- Expansion in the current hospital/health system can keep a competitor out of the customer's locations.

- Expansion into non-call situations can allow the group to add anesthesiologists and reduce the call burden.
- Expansion can provide the ability to “follow the work” if it shifts to other locations.
- If the group can staff the new locations with non-shareholder-track physicians, the new locations can potentially:
 - Increase compensation for current shareholders.
 - Create a “lifeboat” for current shareholders if a contract is lost.

This last point—staffing locations with non-shareholder-track physicians—is controversial. Many anesthesiologists believe that any physician who joins their group should be on a shareholder track. Other anesthesiologists believe that new locations should be staffed by employed physicians who are reimbursed at a lower rate (thus, providing the potential for increased shareholder compensation), and who can be replaced with shareholder physicians if the group loses a significant contract.

Groups that want to grow should also decide on one of the following paths:

- Passive: Only consider opportunities that others bring to them.

Continued on page 12



WHERE DO WE GO FROM HERE? CHOOSING THE RIGHT PATH IN TURBULENT TIMES

Continued from page 11

- Active: Identify target locations and reach out in a friendly way to groups serving those locations.
- Predatory: Identify target locations and reach out to hospital or ASC administration in those locations to replace the current providers. This is anathema to most independent anesthesiologists, but this is the path that many corporate-owned anesthesia groups are taking.

MERGERS WITH OTHER GROUPS

As the rest of healthcare continues to consolidate, anesthesiologists are also looking closely at mergers. What benefits do they hope to achieve? Most groups point to the following potential upsides:

- Retain a reasonable amount of autonomy.
- Elect the group's leaders.
- Increase negotiating clout.
- Avoid being "played" by healthcare systems.
- Expand coverage, including specialty or subspecialty coverage.
- Build critical mass for new programs and services.
- Increase likelihood of survival in light of physician retirements.
- Support rational recruitment of new physicians.
- Share leadership and management expertise.
- Achieve economies of scale and efficiencies (but only with integration).
- Take first step toward further integration.

The benefits are, of course, different for different situations. In urban environ-

ments the focus is typically on the following benefits:

- Share physicians.
- Avoid being played.
- If the hospital becomes part of a system, merge before "winners and losers" are chosen. Rational recruitment.
- Economies of scale.
- Share best practices.
- Share management.

While groups in a less urban setting are pursuing some of the above benefits, their initial merger is often the first step that sets the stage to bring in other groups.

For information on the steps involved in merging with other groups, please see "[Anesthesia Group Mergers: Strategies for Success](#)," *Communiqué*, Spring 2015.

EMPLOYMENT

Hospital employment is typically perceived as a negative step for most groups. However, some anesthesiologists point to the fact that changing payment mechanisms may put the control over all anesthesia reimbursement into the hands of the hospital or other physicians, and that this may have some advantages. (One anesthesiologist told me, "I hope the hospital will make all those decisions. My physician colleagues in other specialties won't pay me one cent.")

Some physicians say that if the hospital totally controls the reimbursement of anesthesiology groups, the anesthesiologists may become *de facto* employees, and therefore, the group should negotiate employment while it still has some leverage.

SELLING OUT

Selling out has been the "hot topic" over the past several years as national firms dangle shiny objects (cash) in front of anesthesiologists. When I think of these "opportunities" I am reminded of Timothy Ferriss's quote from *The 4-Hour Workweek*, "Most people will choose unhappiness over uncertainty."

The details of the valuation and sale processes of this alternative are beyond the scope of this article. However, Exhibit 1 provides a number of questions that group members should ask if they consider this alternative.

EXHIBIT 1

Questions to Ask Before Selling

1. How much autonomy will we really have?
2. How much money are we really getting, and how much will we pay back? Will that amount of money really change our lives?
3. What happens at the end of our contract?
4. If you say we will be compensated at a "market rate" what do you mean by "market rate"?
5. What is the company's long-range business plan?
6. What does the non-compete agreement look like?
7. What happens if we go bankrupt?
8. What happens to us if we lose the hospital contract?
9. What happens if our division's profitability decreases?



While it is true that the acquiring company will pay the physicians cash for their practice, it may provide clout to negotiate for contracts, and may offer tools and techniques to help with new payment mechanisms, the primary downside is a loss of autonomy. The acquiring company will likely tell you that they will not interfere with the issues that are most important to the anesthesiologists, such as scheduling, staffing and internal governance. However, they will have the final say on issues, especially those that have any type of financial impact. Further, if, at some point, profitability is threatened, will they stick to this “hands off” approach?

As you consider this alternative, it is important to remember that the person you talk to about an option may have incentives not to tell you the whole story. You typically expect this from the “sales” people, but not from other physicians. However, many employment contracts for those who have sold out include non-disparagement clauses (in which the physician can be fired if they say something bad about the company), and few physicians want to go home and tell their spouses they have to move.

Further, there are rumors that physicians who have already sold their practice may receive an incentive payment if they participate in convincing your group to join their organization. While the physician in the acquiring organization may not have either of those incentives, the best path is to take everything you hear from people associated with the purchasing organization

with a grain of salt even if you went to medical school with them or they are your best friend. Okay, if it's your mother, you can probably trust her.

Further, many of the professionals associated with selling the practice have strong incentives to promote a sale:

- Valuation firms make money helping you determine how much money to negotiate for.
- Investment bankers make their money only when a transaction occurs.
- Lawyers and accountants love the opportunity to help you examine the alternatives.

However, these concerns are often overshadowed by the chance for immediate financial gain (people really like cash). After noting these concerns at a recent conference, almost every followup question was how to optimize the valuation process so that the group members get the highest price.

If you do decide to look at this option, keep the following in mind:

1. Just considering this option will put a major strain on group cohesion. Physicians will disagree on whether to pursue a deal and how the deal should be structured. Paranoia and mistrust will grow. If you decide not to pursue a transaction, it will likely take years to repair relationships.
2. Once you are acquired, every physician becomes an independent player. Our discussions with members of groups who have been acquired indicate that almost all cohesion goes out the door.
3. Your hospital may say “no,” i.e., not assign the contract to the acquiring firm. It's probably better to find this out before you spend hundreds of thousands of dollars analyzing a purchase offer.

4. Before you get too far into the process, Google and read the cautionary tales of the following enterprises:

- Phycor
- MedPartners
- Ortholink

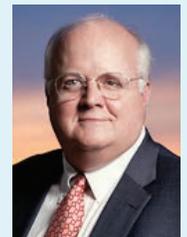
STRATEGIC PLANNING

What's the best strategic direction for your group? As every consultant is trained to say, “It depends.”

It depends on your local situation, your feelings about autonomy, your group's energy to pursue initiatives and many other factors.

This is why many groups devote time and resources to developing a strategic plan. This is a group endeavor. Details about the benefits of and steps in this process may be found in [“Hope Is Not a Strategy: A Primer for Anesthesia Groups on Strategic Planning,”](#) *Communiqué*, Fall 2016. 

Will Latham, MBA is President of Latham Consulting Group, Inc., which helps medical group physicians make decisions, resolve conflict and move forward. For more than 25



years Mr. Latham has assisted medical groups in the areas of strategy and planning, governance and organizational effectiveness, and mergers, alliances and networks. During this time he has facilitated over 900 meetings or retreats for medical groups; helped hundreds of medical groups develop strategic plans to guide their growth and development; helped over 130 medical groups improve their governance systems and change their compensation plans; and advised and facilitated the mergers of over 120 medical practices representing over 1,200 physicians. Mr. Latham has an MBA from the University of North Carolina in Charlotte. He is a frequent speaker at local, state, national and specialty-specific healthcare conferences. Mr. Latham can be reached at (704) 365-8889 or wllatham@lathamconsulting.com.

HOSPITAL CEO TURNOVER: WHAT YOU MUST KNOW AND DO TO PROTECT YOUR ANESTHESIA GROUP

Mark F. Weiss, JD

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You and I are sitting in the hospital boardroom directly across from the hospital's CEO.

We're negotiating the last few points on the renewal of your group's exclusive contract.

Perhaps we're pushing for something minor in the scope of things, but it's still important to your group. For example, it could be for continuing the funding of the surgeon satisfaction program, an element of our locking strategy at the facility.

Or, perhaps we're pushing for something major, such as the ability to delay the mandated 7:00 a.m. start time in all ORs on the third Wednesday of each month, the date of the anesthesia department meeting.

The CEO leans forward and says, "I'll make sure that the funding continues and I can give you start time flexibility on that one day a month, but I can't put it in the agreement. You've known me for years. Trust me on this. You have my word."

"Trust me." Those are famous words from a hospital CEO. And maybe, just maybe, you can trust them. In fact, let's say that you absolutely can. But, can you trust their successor? And are you willing to take the chance?

ASSESSING THE ODDS

Earlier this year, the American College of Healthcare Executives (ACHE) released its annual hospital CEO turnover report. (<https://www.ache.org/pubs/Releases/2017/2017-Hospital-CEO-Turnover-Rate.cfm>)



As reported by the ACHE, hospital CEO job *insecurity* has held steady for the past three years at an 18 percent turnover rate. Although down from the record high of 20 percent in 2016, the current hospital CEO insecurity rate is among the highest in the past two decades.

That means that there's almost a 20 percent chance that your hospital's CEO won't be on the hospital's payroll a year from now, whether they're sitting across the table from you or sitting in their office two floors away. In fact, according to the ACHE report, depending on where in the U.S. you're located, the chances could be as high as 67 percent that they'll soon be gone.

ACHE President Deborah J. Bowen states that the data "underscores the importance of those organizations having

succession plans to successfully manage C-suite changes." Gee, that sounds great and all MBA-like.

But what about from your perspective; that is, from the perspective of an anesthesia group leader? What does the high level of CEO job insecurity mean for you?

Here are a few thoughts:

1. Trust, but verify . . . in writing.

If you have any type of contract with a hospital, no matter how much you trust "CEO Sally" to be a woman of her word, *contractual promises must actually be in the contract.*

That's because when Sally's successor, "Sam," takes over, he'll look at your contract and won't see, or be bound by, anything not actually in it.

So remember words like these when CEO Sally says, "Trust me." "Yes, Sally, I

trust you, I really trust you. But I don't know who your successor might be, and I can't trust them." And if, despite your best efforts, you can't get those promises in writing, at least don't fool yourself. They're not enforceable.

2. Build wide relationships.

You must develop relationships with as deep a bench of hospital administrators, board members and key medical staff members as possible.

When the current CEO leaves for their new position in the food service industry, you'll need their backing when the CEO's replacement arrives. In fact, one of them might even become the new CEO.

3. Understand human nature.

New CEOs like to put their own stamp on things. That means thinking about doing a request for proposal (RFP) for anesthesia services...just because they can. Or it means skipping an RFP and simply replacing you with the XYZ group, because they were at the new CEO's old facility.

You can't control the outcome, but only attempt to influence it. See point number two, above.

And, as a corollary, always run your group's business and deliver services as if your future depends upon it. That's because it does. But understand that, even



if you've done everything right, you can't be certain that the new CEO won't disrupt the relationship.

4. Don't bet on just one horse.

The days of being loyal to just one hospital ended long before hospitals ended being loyal to anesthesia groups.

Spread your risk. Grow your group's business to provide services at multiple facilities. If the new CEO decides not to renew, or, even worse, terminate, your contract, you don't want it to mean the termination of your group's existence.

5. Play both offense and defense.

At the same time that you focus on playing offense, growing your group's business per point number four, you've got to practice defense, too.

Take steps to protect your group from encroachment by both external and internal competition. Note that "internal" means both internal to the group and to the hospital.

So, for example, engage in locking strategies (such as the above-mentioned surgeon satisfaction program), consider the use of not-to-compete covenants and other protective measures, and build anti-staffing provisions into your exclusive

contracts, employment agreements and subcontracts.

6. Think on the bright side.

If your hospital's CEO is a jerk, remember that every cloud has a silver lining. There's a one in five or better chance that they won't be with you for long. So, buy "Good Luck!" and "Happy Retirement!" cards at a discount when they're on sale.

Hospital CEOs always want you to cut costs and they'll appreciate your foresight. Just don't let them know ahead of time. ▲



Mark F. Weiss, JD is an attorney who specializes in the business and legal issues affecting physicians and physician groups on a national basis. He served as a clinical assistant



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YOUR HOSPITAL ISSUES AN RFP FOR ANESTHESIA SERVICES: NOW WHAT?

Robert Johnson, MBA

Principal, Enhance Healthcare Consulting, Aventura, FL

Robert Stiefel, MD

Co-Founder and Principal, Enhance Healthcare Consulting, Aventura, FL

As a national anesthesia consulting firm, we are seeing hospitals and health-care systems change or attempt to change their incumbent anesthesia groups with increasing frequency. A recent survey of hospital leadership has confirmed our experience and demonstrates that the mechanism by which hospitals seek to effect a change is frequently through a request for proposal (RFP). This term should not be new to most anesthesia groups, but we have discovered that some of our clients first encounter the term when they receive an RFP from their own hospital—and then wish they had been more familiar with the term and resulting process.

This first of two articles for *Communique* will review why hospitals seek alternatives to their existing anesthesia groups, early warning signs to groups that may indicate their hospital is seeking a



change, and how that interest may result in an RFP being sent to the incumbent and other potential provider groups. Finally, we will discuss typical steps employed in the creation of the RFP,

including a review of the RFP response document.

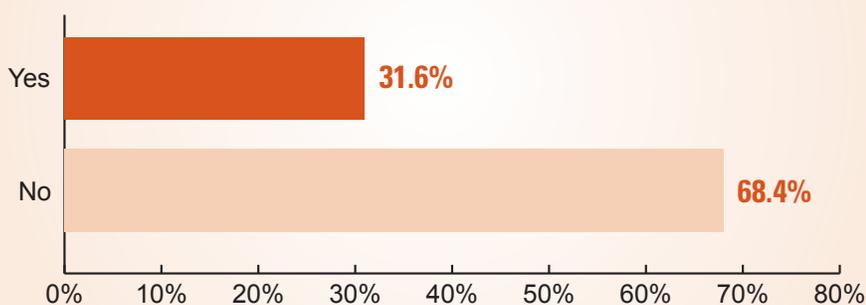
The second article will examine the decision processes hospital leaders may employ and demonstrate how we believe your anesthesia practice should be prepared to respond.

Many industries use RFPs to purchase goods and services. Hospital purchasing departments use them to procure everything from medical devices to housekeeping services. The advantage of the process is that it allows the hospital to demonstrate impartiality in their selection of a service or product. For this reason, RFPs are highly structured and typically performed in a transparent manner. Per a survey by Enhance Healthcare Consulting (EHC), one in three hospitals has issued an RFP for anesthesia services since 2013 (see Figure 1).

FIGURE 1

Enhance Healthcare Survey, 2016 (215 Hospitals)

Has Your Organization Issued a Request for Proposal for Anesthesia Services in the Past Three Years?



In the not-too-distant past, hospitals often used an RFP to introduce the threat of an outside vendor taking over the contract and to influence negotiations in their favor with the incumbent anesthesia group. However, both parties generally knew that the expected high transition costs and loyalty of the medical staff made the selection of a new practice highly unlikely. Therefore, efforts to identify a possible replacement group were casually performed with few guidelines and rarely resulted in a change from the incumbent provider.

However, shifts in provider supply and demand, group consolidation, oligopolistic health insurance entities and the rise of investor-owned hospital-based physician practices (e.g., Sheridan/EmCare, TeamHealth, NAPA) have created local environments in which hospitals seek "partners" utilizing more sophisticated business practices and better technology and willing to share financial risk. Before discussing the group attributes that a hospital may be looking for with an RFP, let's first look at the reasons that cause a hospital to seek a change in the incumbent group.



WHAT MOTIVATES AN RFP?

EHC's work with both anesthesia groups and hospitals to set up, conduct and respond to RFPs allows us unique insight into what motivates a hospital CEO to seek a change in anesthesia providers. For the past decade, anesthesia conferences have been replete with speakers encouraging groups to understand their customers—surgeons, hospital administration and patients—and to address those customers' needs or risk losing their hospital contract. Excellent clinical quality was a given, but "customer service" was not. Consultants encouraged groups to focus more attention in this area.¹

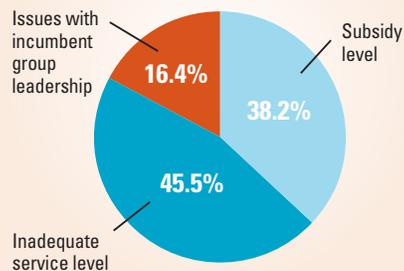
While emphasizing the importance of satisfying the customers, industry experts pointed out that the logical next step for hospitals was to consider alternatives. Jody Locke, vice president of anesthesia and pain practice management services for Anesthesia Business Consultants, has stated that "Market competition is based on the premise that customers

have options and that they will seek service providers who they believe are most committed to meeting their specific needs and expectations."² It is our observation that when hospital leaders perceive customer service that does not meet their needs and expectations, they look for someone else. We are seeing this with increasing regularity. Our survey (see Chart 1) bears this out. Unfortunately, assessing anesthesia customer service is a problem. Our experience is that hospital leaders may simply judge anesthesia service by the number of times the surgeons call their office with complaints.

Service issues commonly cited by others include poor personnel management and the incumbent group's failure to address disruptive behavior by an anesthesiologist. EHC would add that service, in the mind of a hospital CEO, is simply being in the operating room and ready for surgery when you are needed without anyone having to ask. A senior health system administrator once relayed to one of the authors that the best anesthesia group that ever worked at his hospital was one that he never met. Unfortunately, for anesthesiologists, that often means staff-

CHART 1

What was the primary reason for issuing the RFP?



¹ Johnson, Robert, presentation at Conference on Practice Management, American Society of Anesthesiologists, January 2007.

² Locke, Jody, Anesthesia Customer Service, *Communiqué*, Anesthesia Business Consultants, LLC Summer 2006. <http://www.anesthesiallc.com/publications/communique/75-communique/past-issues/summer-2006/166-anesthesia-customer-service>



YOUR HOSPITAL ISSUES AN RFP FOR ANESTHESIA SERVICES: NOW WHAT?

Continued from page 17



ing an OR without a patient and not being reimbursed.

This relates to another key reason for issuing an RFP: financial support from the hospital as a subsidy, stipend or compensation for services. Little documentation is available on the frequency and amount of financial support that hospitals provide to their anesthesia groups.

According to a Medical Group Management Association survey, the revenue from hospital sources to privately owned anesthesiology practices was \$118,014 per FTE physician.³ Since that amount may represent a significant part of your practice revenue and a large percentage of the hospital's overall budget for physicians, the issue of subsidy support may disproportionately dominate the contract negotiations.

A third commonly cited category of discontent measured in our survey is the hospital's unhappiness with anesthesia group leadership. An article in *OR Manager* lists four attributes of an effective anesthesia leader: 1) ability to manage operations, i.e., works with nursing to run the board; 2) efficiency—uses personnel efficiently to maximize throughput; 3) safety—emphasizes safe practices; and 4) participates in governance, specifically the Surgical Services Executive Committee (SSEC).⁴

It is important to point out that the physician leader of a group will have an enormous effect on the CEO's and medical staffs' perception of the group's overall quality. This individual's personal characteristics will influence the CEO's desire to change groups more than the

group itself, whose members are almost always described as “nice guys.” Therefore, groups need to be careful in selecting who represents them and be aware that if their model is to rotate partners into leadership positions, a person who doesn't impress the group also won't impress the CEO.

SIGNS AN RFP MAY BE COMING

A hospital may start to look for an alternative to your services at certain times, which include, but are not limited to, contract termination or renewal. An unscheduled or atypical call to visit the CEO may indicate a change in the hospital's direction. Certainly, if the meeting is negative and the CEO complains about your group, that's an obvious red flag. However, be cautioned not to be fooled by the friendly meeting. We have seen more than a few meetings that go well, with everyone smiling and in which nothing

³ Medical Group Management Association, 2015 Cost and Revenue Report Based on 2014 Survey Data, pp. 90-94.

⁴ Bierstein, Karin, “Achieving anesthesia provider accountability will boost OR performance,” *OR Manager*, Vol. 31, No. 2, February 2015.



unpleasant is discussed, except at the end, when the CEO says, “We love you and the group is great, but we may be testing the waters to see what’s out there; have a good night.”

Another indicator of impending change is any unusual efforts by the hospital to acquire or collect information about your group’s finances and performance.

Since it is apparent that hospitals are increasingly using the RFP process to evaluate and replace their anesthesia group, it is important to understand how the process works. Once the decision is made to issue an RFP, the CEO usually selects an individual to manage the process.



Large hospitals may have a purchasing department with a procurement executive who may utilize the same process used to procure surgical packs or cleaning supplies. These individuals tend to be rigid and lack understanding of the complexities of anesthesia services. Fortunately, they are the minority. More frequently, the task is given to the chief operating officer, chief financial officer or external consultant.

If you become aware of the possibility of a consultant assisting the hospital in an evaluation of your group’s performance or with an RFP, consider asking to participate in the consultant selection process. It is worth the anesthesia group’s investment to pay a portion (typically 50 percent) of the fee and thereby have access to the information that will be used by the consultant and the opportunity to demonstrate to the hospital the quality of your service and avoid the RFP.

In our next article, we will discuss the importance of providing accurate information about your anesthesia group if the hospital issues an RFP. We will also discuss what to expect from an RFP process and how an incumbent group should respond. But for those of you on

the edge of your seats, spoiler alert: the best way to deal with an RFP is to not get one in the first place! 

Enhance Healthcare Consulting is an anesthesia services consulting firm providing expert assistance to both hospitals and anesthesia groups seeking to improve their financial and operational performance.

Robert Johnson, MBA,

Principal at Enhance Healthcare Consulting, is a healthcare executive with broad experience in multiple healthcare environments. He started at Johns Hopkins Hospital as a perfusionist in the cardiac operating rooms and eventually became administrator of the anesthesiology department. He has also served as senior associate chief operating officer at Duke Hospital and held positions with Baylor College of Medicine, the University of Pittsburgh and Sheridan Healthcare. As a vice president for HCA, he played a critical role in leading negotiations with hospital-based physician practices. He joined EHC as a principal in 2014. He can be reached at bob.johnson@enhancehc.com or (404) 905-7014.



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What You Don't Know Can Hurt You.... Understand and Meet the QPP Requirements

The Medicare Access & CHIP Reauthorization Act of 2015 (MACRA) marked the end of Medicare payment's fee-for-service model and the beginning of a performance-based payment system, the Quality Payment Program (QPP). The QPP offers the choice of two tracks: the Advanced Alternative Payment Models (APMs) or the Merit-Based Incentive Payment System (MIPS). Most anesthesia practitioners participating in the QPP in 2017 will utilize MIPS.

As CMS transitions to a pay-for-performance methodology, it is easy to get lost in the acronyms and the policy. The co-sourced **MACRA MadeEasy** certified Qualified Clinical Data Registry (QCDR) platform guides clients through these changes and provides a structured and practice-specific

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The pioneering **MACRA MadeEasy** platform can help usher you into the future of healthcare and walk you through the steps utilizing:

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PROFESSIONAL EVENTS

Date	Event	Location	Contact Info
August 11-13, 2017	American Society for Gastrointestinal Endoscopy GI Outlook 2017: The Practice Management Conference	Loews Hollywood Hotel Hollywood, CA	https://www.asge.org/home/practice-support/courses-conferences/gi-outlook-go-the-practice-management-conference
August 25-27, 2017	American Society of Anesthesiologists INSIGHTS + INNOVATIONS™ 2017 Conference	Hyatt Regency Huntington Beach Resort & Spa Huntington Beach, CA	http://www.asahq.org/i2conference
September 7-10, 2017	Texas Society of Anesthesiologists 2017 Annual Meeting	JW Marriott San Antonio Hill Country Resort & Spa San Antonio, TX	https://www.tsa.org/apps/register
September 9, 2017	Washington State Society of Anesthesiologists 2017 Fall Scientific Meeting	Bell Harbor International Conference Center Seattle, WA	http://www.wa-anesthesiology.org/index.php?option=com_mc&view=mc&mcid=72&eventId=519437&orgId=wassa
September 16-17, 2017	Ohio Society of Anesthesiologists 78th Annual Meeting	Hilton Columbus at Easton Columbus, OH	http://www.ohiosa.com/annual-meeting-information/
September 14-17, 2017	New England Society of Anesthesiologists 60th Annual Meeting	Ocean Edge Resort & Golf Club Brewster, MA	http://nesa.net/NESA/AnnualMeeting%20Pages/AnnMtg2017prov.html
September 30, 2017	Illinois Society of Anesthesiologists 2017 Leadership and Professional Development Conference	ASA Headquarters Schaumburg, IL	https://www.isahq.org/events
October 7-11, 2017	American Health Information Management Association 2017 Convention and Exhibit	Los Angeles Convention Center Los Angeles, CA	http://www.ahima.org/convention/geninfo
October 9-14, 2017	American Association of Oral and Maxillofacial Surgeons 99th Annual Meeting, Scientific Sessions and Exhibition	Moscone Convention Center San Francisco, CA	http://www.aaoms.org/meetings-exhibitions/annual-meeting/99th-annual-meeting
October 20, 2017	American Society of Anesthesiologists International Forum on Perioperative Safety & Quality	Seaport Hotel Boston, MA	https://www.asahq.org/ifpsq
October 21-25, 2017	American Society of Anesthesiologists ANESTHESIOLOGY™ 2017 Annual Meeting	Boston Convention & Exhibition Center Boston, MA	https://www.asahq.org/annualmeeting/?utm_source=asahq&utm_medium=landing-page&utm_campaign=Annual-Meeting

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