



MACRA's PHYSICIAN-FOCUSED ALTERNATIVE PAYMENT MODEL OPTIONS: A MULTISPECIALTY PERSPECTIVE

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The Medicare Access and CHIP Reauthorization Act (MACRA), which replaced the perennial Sustainable Growth Rate (SGR) formula, created two options for compliance. The first path, which does not require assumption of insurance risks, is the Merit-Based Incentive Payment System (MIPS) that consolidated existing quality programs and added clinical practice improvement. The other fork in the new highway is the Alternative Payment Model (APM), with one subgroup variant being the Physician-Focused (PF-APM), in which the physician accepts some level of risk for services and expenses over which they have some control. Another subgroup variant is the Hospital-Focused (HF-APM). This article focuses on PF-APMs with an emphasis on potential multispecialty models that may provide



subtle opportunities or be developed by others in the community where anesthesia may play a role. While physicians may have a wide range of experience with some MIPS elements, few physicians have any idea how APMs might apply to their practice.

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ANESTHESIA'S TRANSITION TO VALUE-BASED CARE

The fate of the Affordable Care Act (ACA) remains unclear following the outcome of the presidential and Congressional elections (with president-elect Trump stating his desire and Republicans in both House and Senate showing their zeal to repeal the ACA, as discussed in our final [eAlert](#) of 2016). The bipartisan Medicare Access and CHIP Reauthorization Act (MACRA) and the healthcare sector's transition to value-based care are expected to remain intact, however. As Andy Slavitt, acting administrator of the Centers for Medicare and Medicaid Services (CMS), advises eligible clinicians, move ahead as planned with your participation in the Quality Payment Program (QPP).

Considering the QPP's newness and complexity, many clinicians are likely to feel some uncertainty regarding what they must report, how they must report it and how they will fare under the new Medicare payment system. According to a national survey of more than 17,000 physicians by The Physicians Foundation reported in September, only 20 percent of respondents indicated they were somewhat or very familiar with the system.¹

To assist in this first performance year, Kathryn Hickner, Esq. returns to this issue with an overview of the QPP and its two tracks, the Merit-Based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs). Ms. Hickner encourages anesthesia providers to "promptly and proactively develop a strategy to thrive under MACRA and the QPP," noting that CMS expects the majority of eligible clinicians to participate in MIPS in this initial performance year and anticipates that 90 percent will receive a neutral or positive payment adjustment. To us, that looks like a clear sign that the QPP can be met with confidence.

Although most eligible clinicians are expected to participate in MIPS in the QPP's first year, CMS expects clinicians to eventually participate in APMs, so it is not too soon for those of you who are not already in APMs to explore the possibilities. Anesthesia consultant Asa C. Lockhart, MD, MBA takes us on a brief but intriguing journey of some potential options developed by the American Medical Association and the Center for Healthcare Quality and Payment Reform.

An innovative care delivery model that is gaining traction within anesthesiology and with which many of you are already familiar is the perioperative surgical home (PSH). In his sixth in a series of articles on the PSH, Rick Bushnell, MD, MBA discusses how anesthesiologists can parlay the clinical skills they already have to optimize and risk-stratify patients during the preoperative appointment that is a hallmark of the PSH.

Regardless of what happens to it in the next few years, the historic and controversial ACA has left its mark on American healthcare and healthcare payment. According to Maurice Madore, MBA, CPC, chief client officer of Anesthesia Business Consultants, while millions fewer Americans lack healthcare coverage as a result of the ACA, "providers have been forced to restructure how they get paid for services as patients have become responsible for a higher percentage of their healthcare costs."

Also in this issue:

- Consultant Will Latham, MBA gives us another article on strategic business planning. This time, Mr. Latham probes the ins and outs of the strategic planning retreat, providing practical advice

on organizing the event and keeping it on track.

- Frequent contributor Mark F. Weiss, JD discusses the little known "verein" or confederation model, a potential business structure for anesthesia groups interested in forming a larger structure out of existing groups that "frees the organizers from many of the problems encountered in creating alignment." The verein structure "lowers the barrier of 'trust to entry,'" Mr. Weiss writes. "It's far easier to trust in a vision if it doesn't require giving up your ownership and local control, and becoming liable for someone else's debts."
- Jody Locke, MA vice president of anesthesia and pain practice management for ABC, reviews the evolution of the electronic medical record in anesthesia, sheds light on why EMR implementation within the specialty is often fraught with challenges, and offers guidance to anesthesia practices for avoiding some of the obstacles.

We look forward to seeing many of you at the 2017 ASA Practice Management Conference in Grapevine, Texas.

With best wishes,

Tony Mira
President and CEO



¹ 2016 Survey of America's Physicians: Practice Patterns & Perspectives, The Physicians Foundation, September 2016. http://www.physiciansfoundation.org/uploads/default/Biennial_Physician_Survey_2016.pdf



THE PERIOPERATIVE SURGICAL HOME: PREOPERATIVE RISK STRATIFICATION, OPTIMIZATION AND VALUE

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Payers, patients and partners are demanding better outcomes, and evolving healthcare paradigms are begging for greater anesthesia engagement. If you have been following this series, then you already know that the perioperative surgical home (PSH) is the answer to the call and the future of our specialty. What you may not know is how easy it can be as an anesthesiologist to make a contribution.

Stationing an anesthesiologist in the preoperative clinic is magic. The presence of anesthesia medical knowledge is magic to the preoperative nurses, magic to the patients and magic to the surgeons. Preoperative clinic nurses need support and direction when complicated patients present. Surgeons need the ability to obtain an anesthesia consult and patients truly need reassurance sooner than three minutes before surgery that the entire surgical continuum is engaged for their benefit.

Anesthesia offers major value to all of these people. The fact that we self-limit our presence to three minutes before surgery sends the message that we are unengaged. As anesthesiologists, we know nothing could be farther from the truth. We each have spent years developing the skills needed to spot trouble. Too often, though, we're spotting it too late in the process and off-loading the medical issues, responsibility and leadership.



It is now time to translate our intuitive anesthesia preoperative skills into more objective assessments, management and leadership. The PSH provides the practice platform by which to lead the entire surgical process and continuum. The anesthesia preoperative appointment uses the same skills you have honed for years. It consists of a directed anesthesia history and physical, risk stratification and management. You already know how to assess a patient and past medical record, so I'll save the lecture. What's new and improved is the use of the American College of Surgeons National Surgical Quality Improvement Program (NSQIP)¹ to objectify and augment your professional intuition and communicate the information effectively to others.

Consider the 83-year-old patient I recently saw in our PSH. She presented for right total knee arthroplasty with a diagnosis of diabetes, chronic poorly controlled hypertension, 3+ pitting edema at the ankles and no cardiac consult. Her [NSQIP calculation](#) is shown in Figure 1. Easy enough; I sent her for a cardiac consult, and the echocardiogram results came back with a hyper-dynamic heart, 81 percent ejection fractions and an ascending aortic root dilation of 4.8 cm (severe). The preoperative clinic appointment, the consult and the surgical risk calculator all facilitated a more timely and objective conversation between the surgeon, the patient and the anesthesiologist. This would not have

¹ American College of Surgeons National Surgical Quality Improvement Program®, <https://www.facs.org/quality-programs/acs-nsqip>

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Our current system is oriented toward intervention and what is possible; emerging models emphasize prevention and experientially-based minimization of avoidable complications. Modeling focuses on balancing optimization of outcomes, costs and patient satisfaction versus fragmented silos of care (e.g., particular physicians or specialties). Disconnects between the consumer (patient) and the producer (professionals) are barriers to balancing costs and utility. The current system does not value or anticipate the questions of how often it meets expectations, at what costs and relative risks. Additionally, the patient has no affirmative responsibility to optimize their personal health. And finally, the system itself is a barrier.

BARRIERS TO REDESIGN

Existing models may not address barriers to redesigning services that may provide higher value to healthcare. To innovate, one must have the latitude to reallocate precious but limited resources and have space to make the transition. Two commonly mentioned barriers are either no or inadequate payment for many high-value services and transitional financial risk for a different mix of services despite reduced costs to society. Patients may benefit from enhanced personal time in an alternative model or pursue lower cost options with improved or neutral outcomes. Yet we are not paid to take the time to counsel patients on lifestyle or various options available to them that are time-intensive or require relational databases. Physicians are best positioned to evaluate alternative delivery systems and optimize cost delivery settings and different combinations of services and providers. But that



takes time and requires support and resources (human and financial capital) not currently available. It also takes an alignment of incentives that focus more on outcome, utility and coordination rather than component production and what is merely possible. A transition from the current model to emerging models still requires keeping the doors open! As current transactional practice revenue decreases with the delivery of fewer or lower cost services, a transitional strategy will be necessary to shield operating losses, as changes will not be proportional and may even be higher in a temporarily dual system.

No or inadequate payment is a barrier to both Medicare and private health plans for high-value services that would benefit patients and help reduce avoidable spending. For example, responding to a phone call about a symptom or problem might help patients avoid a more expensive ER visit. There is no recognition of the value of coordination of care between primary care physicians and specialists for the time

saved by avoiding duplicate tests or conflicting medications, or for facilitating discharge planning in emergency departments to enable safe discharge without hospitalization. A proactive, early-stage telephone call might optimize preventive care and lower comorbidities in high-risk patients. Patients, especially deconditioned patients, would benefit from prehabilitation, but there is little support for developing this intervention. Smoking cessation reduces respiratory complications and length of stay as well as improvements in wound dehiscence. Current paradigms do not recognize these benefits. However, a well-designed APM would leverage these opportunities.

Financial penalties for delivering a different mix of services pose transitional risks to physicians in several ways. As their health improves, patients require fewer services or avoid developing a disease. They experience fewer complications and comorbidities requiring intervention. However, despite these improvements, practice overhead does not decrease; rent and utilities are not

pegged to quality of care or resource utilization.

Most APM savings do not come from physician payments; savings can be realized without financial targeting or implicit penalization of physician practices for delivering a societal goal. With healthier patients, physician practices would receive less income under current methodologies. This is the essential problem that must be addressed if we are to make substantial progress as APM options are developed.

What are the prerequisites to overcoming these barriers to successfully create new options? The Center for Healthcare Quality and Payment Reform (CHQPR) has identified three characteristics for enabling change:

1. Flexibility in Care Delivery: the APM must provide enough innovative flexibility and patient-centric focus to deliver a mix of services that makes sense but is not covered within today's payment methodologies to provide new paths to efficiency and effectiveness.
2. Adequacy and Predictability of Payment: it is essential that financial resources be available

to start the process and that there is confidence that the return on investment (ROI) will be there. The fear is that our success will be co-opted. Rules of engagement must deliver adequate and predictable resources to allow physicians to create alternative structures to identify high-quality service opportunities and address both start-up and transitional financial risk to physicians. Exposure must be risk-adjusted to recover the investment yet be within an acceptable financial risk corridor for small business medical practices.

3. Accountability for Costs and Quality Under Physicians' Control: program design must assure non-provider stakeholders (patients and payers) that outlays will be controlled or reduced with an implicit assumption that quality will be maintained or improved. The beauty of PF-APMs is that individual physicians should only be at risk for those aspects of spending and quality they can materially control or influence.

EXAMPLES OF POTENTIAL MODELS

A Guide to Physician-Focused Alternative Payment Models, prepared by the American Medical Association (AMA) and the CHQPR, identifies seven potential models. Since this is an emerging concept with no other resources that synthesize the material as well as this publication, the following excerpts/paraphrases in quotes are from that comprehensive document, followed by examples to stimulate thought on how these models could benefit practices and communities.

“APM #1: Payment for High-Value Services with physician payment for desirable services not currently billable enabling avoidance of other, more expensive services...physician bills and paid for time and resources needed to apply appropriate use criteria and engage in an education/shared decision-making process with patients to determine the most appropriate diagnostic tests.... In contrast to typical shared savings programs, physician payments would not be explicitly tied to how much money that practice saved. Instead, the physician practice would be paid adequately to deliver appropriate services, and the payer saves money by spending less on avoidable services.”

This could be a component of an early-stage perioperative surgical home (PSH) (e.g., preoperative testing protocols, prehabilitation, smoking cessation).

“APM #2: Condition-Based Payment for Physician's Services...physician flexibility to use the most appropriate diagnostic or treatment option for a patient's condition without reducing the operating margins of the physician's practice...flexibility to use the payments for whatever combination of services were most effective—office visits, phone calls, emails.”

Monthly payments targeted to chronic conditions replace evaluation





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and management code limitations. Seamless transitions or smoking cessation achieved during PSH appeals to primary care physicians (PCPs) with global risk with enhanced management of COPD patients.

“APM #3: Multi-Physician Bundled Payment (BP)...the goal is to give multiple physicians providing services to the same patient flexibility and resources needed to redesign their services in coordinated ways to improve quality and reduce the costs of diagnosis or treatment.... Patients benefit as physicians delivering their care work together in more coordinated ways with additional resources and/or flexibility under the bundled payment to deliver different types or combinations of services not currently provided. Payers benefit because new payments enable physicians to deliver care more efficiently, order fewer or lower-cost services from other providers, and/or reduce avoidable complications. Physician practices benefit

from the resources and flexibility to deliver optimal services and coordinated services agnostic to current revenue flow risks to the practices.”

This model has a very high potential and likelihood for anesthesiologists since it offers major benefits and aligns incentives for all stakeholders to coordinate care by virtue of shared risks and rewards. This model would allow acceptance of risks for professional services, especially in circumstances where the facility partner is unable or unwilling to participate.

“APM #4: Physician-Facility Procedure Bundle...the goal is to incentivize physicians to choose the most appropriate facility to deliver particular procedures and to work with the facility to improve efficiency and quality.... Patient benefits from receiving high quality care at the lowest-cost facility with coordinated and efficient care.... Payer benefits because the Alternative Payment Entity (APE) could

accept a lower payment for the bundle than the total separate amounts under current payment systems. Physician practices benefit by using the BP to cover the costs of services not currently billable or inadequate, and by receiving compensation for innovations that reduce costs at the facility.”

This model has a very high potential and likelihood for participation by anesthesiologists since it offers major benefits and aligns management incentives between stakeholders but carries the utility risk of demand for certain services (e.g., GI, cataract). The marked variability in hospital charges will be a significant driver with an opportunity to engage payers. Since anesthesiologists cover multiple sites, they are in a unique position to help select the most efficient or progressive facilities (e.g., stable facilities with good policies and procedures versus lower performing options).

“APM #5: Warranted Payment for Physician Services...the goal is adequate physician payment and flexibility to redesign care to prevent complications with reduced spending needed to treat them.... Contrasting penalties that reduce payments for complications, this approach provides greater upfront resources to redesign care for reduced complications. With the cost of treating some complications built into the warranted payment amount, the physician is not financially penalized when a small number of complications occur yet rewarded for eliminating most or all complications.”

This could be a potential variant of a monetization strategy for a PSH.

“APM #6: Episode Payment for a Procedure...the goal is to give physicians and other providers the ability to deliver comprehensive care during and after





particular procedures or treatments in coordinated, efficient ways...*all* of the costs involved in a procedure encompassing inpatient, rehabilitation services and treating any post-operative complications. The payment amount would be risk-adjusted, anticipating more or less inpatient or post-acute care. Payments would be adjusted based on quality and outcome measures.”

This essentially takes Models 4 and 5 and adds the post-discharge management and readmission risk components. While optimally a later, more mature option after experience in Models 4 and 5, market and political pressures may make this the initial option. The Comprehensive Care for Joint Replacement (CJR) Model added hip and femur fractures as a proposed rule APM in August.

“APM #7: Condition-Based Payment...gives physicians and other providers delivering care for acute or chronic conditions flexibility and accountability to deliver the most appropriate treatment for the patient’s condition in a coordinated, efficient, high-quality manner.”

An example was Condition-Based Payment for Post-Acute Care Following a Hospitalization for spine surgery. This model may be a separate initiative, perhaps with different provider groups, as either an early stand-alone or as an independent but complementary part of Model 3 or 4, but an integral part of Model 6. The post-discharge management of a PSH patient could be a stand-alone approach in some circumstances. In the procedural arena, I do not see this as a long-term option and would predict a rapid integration with one of the other models.

CONCLUSION

We are in the interim final rule phase of rulemaking, and the American Society of Anesthesiologists and AMA are diligently evaluating options to preserve your future. The multiple system options may be payer-designed, facility-designed or physician-designed. Close your eyes and make a guess; of those three options, which avenue is most likely to provide an optimal system that treats our colleagues and our patients in the most equitable

manner? The above options will evolve with both the final rulemaking and system adaptation.

I would like to acknowledge briefing materials contained in the publication *A Guide to Physician-Focused Alternative Payment Models* jointly produced by the AMA and the CHQPR that provided the generous excerpts, direction and resources for this article. I would like to thank Sandra Marks (AMA) and Harold Miller (CHQPR) for their copyright permission in general, allowed use of generous excerpts and edits in particular. For a deeper understanding of how you can take control of your future, this excellent resource may be accessed at: www.ama-assn.org/ama/pub/advocacy/topics/medicare-alternative-payments-models.page 

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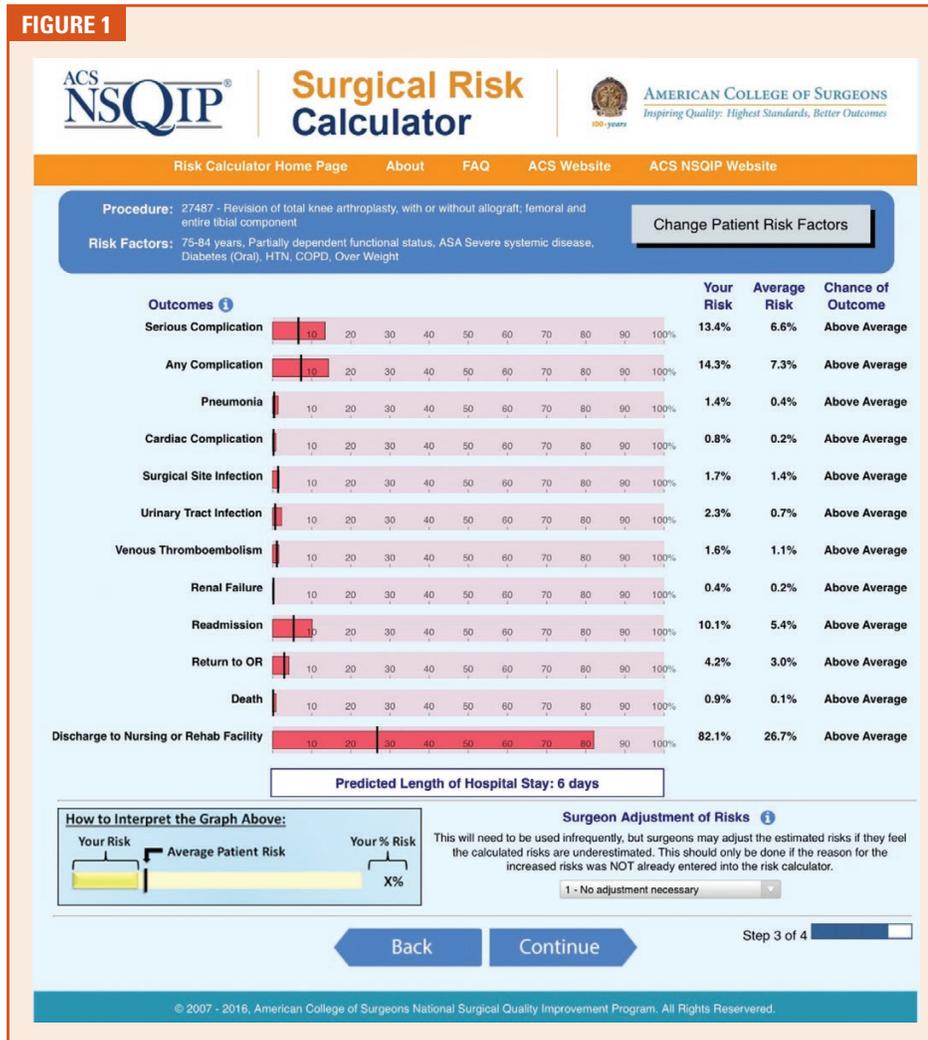
stabilization strategies for more than 185 hospitals and/or anesthesia groups and departments in 37 states. In addition to his consulting work, Dr. Lockhart had an active anesthesia practice in Tyler, TX and has an MBA with an emphasis in healthcare that brings validity and insight to the challenges facing many anesthesia groups and hospitals. Dr. Lockhart is the founder and course director for the ASA Certificate in Business Administration Course created by the ASA Committee on Practice Management. He was also a member of the ASA Committee on Future Models of Anesthesia Practice and has served as president and treasurer of the Texas Society of Anesthesiologists. He serves on the AMA Council on Medical Services, which develops healthcare policy options for consideration by the AMA House of Delegates, and is a vice-chair with the National Physicians’ Council for Health Care Policy. He can be reached at (903) 521-6728 and aclhart@goldencaduceusconsultants.com.



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FIGURE 1



been possible on the day of surgery, if the edema had been caught at all. This process saved time, money and maybe a life, all well worth the investment in the PSH.

For cases that are allowed to proceed to surgery, the PSH appointment then becomes about optimization. Consider the Generalized Protocol for Enhanced Recovery After Surgery (ERAS). As an anesthesiologist, you control the largest portion of this protocol and you stand to make a huge contribution right there. This is because the largest portion of ERAS involves the avoidance of opioids. That avoidance starts during the PSH preoperative appointment. In our preoperative appointments, we start patients on a seven-day regimen of acetaminophen, Celebrex and gabapentin (two days preoperatively and five days postoperatively). By coupling this with intraoperative ultrasound regional nerve blocks, we have reduced our opioid requirements by 75 percent. (The depiction of the first-order pharmacokinetic dosing logic and the timing of surgical incision are shown in Figure 3.)

FIGURE 2

The Generalized Protocol For Enhanced Recovery After Surgery (ERAs)

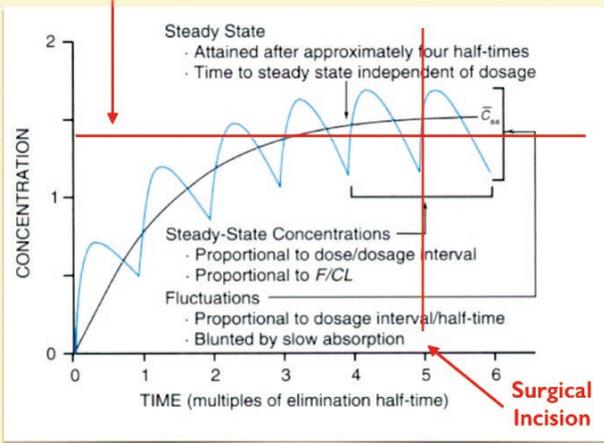
Preoperative Phase	Intraoperative Phase	Postoperative Phase
<ul style="list-style-type: none"> *Patient/family education *Shortened fasting *Fluid & carbohydrate loading No bowel preparation *Antibiotic prophylaxis Thromboprophylaxis *No premedication 	<ul style="list-style-type: none"> *Epidural/regional blocks Laparoscopic/minimally invasive surgery *Normothermia *Perioperative fluid management Avoidance of tubes, drains, and lines 	<ul style="list-style-type: none"> Early removal of urinary catheter No nasogastric tube *Avoid salt and water overload *Prevention of PONV *Non-opioid oral analgesia Early oral nutrition **Early mobilization *Defined discharge criteria and patient education Gum chewing

Notes: *Anesthesia-specific areas of care **Maintain lower extremity function, if using regional anesthesia

FIGURE 3

The Depiction of the First-Order Pharmacokinetic Dosing Logic and the Timing of Surgical Incision

Optimized therapeutic steady state



Dose PO medications 5 half-lives to achieve steady state therapeutic orthopedic pain plasma levels

Pain management in the PSH—a service that only an anesthesiologist can provide—is essential for the effective delivery of the core ERAS protocols. Other portions of our protocol include two days of twice-daily skin decolonization (Hibiclens protocol for the surgical site), two days of pulmonary preconditioning with an incentive spirometer, and

two days of amino acid, carbohydrate and essential fatty acid loading (immunonutritional optimization). Additionally, we should not underestimate the importance of the message being delivered by an anesthesiologist. Coaching by an anesthesiologist on these optimization protocols sends a powerful message to patients of the importance of their own

medical outcome: “This is your surgery and your outcome and this is how to get the best result.” Mid-level providers do not have the credibility to deliver this message as effectively.

The PSH, NSQIP, ERAS and post-operative results can most effectively be managed by a physician anesthesiologist. It means using the skills you already have and understanding the importance of objective risk stratification and optimization. This is real value that only you as an anesthesiologist can deliver. These are positive outcomes that will become evident in your hospital’s quality metrics and increase your anesthesia group’s value to your institution. That value and those metrics will be useful in negotiations with your accountable care organization.

As the 5th century B.C. Japanese warlord Sun Tzu said: “Victorious warriors win first, then go to war.” Win first with your risk stratification, with your optimization and by demonstrating value in your metrics, and *then* have that ACO conversation. 🏠



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THE MACRA QUALITY PAYMENT PROGRAM IS HERE. ARE YOU READY?

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You have heard of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and, most likely, its Quality Payment Program (QPP). But do you *really* know what it is? Do you know what it means to your practice? Do you know what your practice will need to do to thrive under the QPP? If you haven't already, you'll need to develop a firm understanding of the reimbursement landscape under MACRA. The time is now. Ready. Set. Go.



BACKGROUND AND CONTEXT

In October 2016, the Centers for Medicare and Medicaid Services (CMS) issued the MACRA final rule with comment period titled “Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models” (the Final Rule).¹

Although it is more than 800 pages long, the MACRA final rule is designed to simplify participation by eligible clinicians. MACRA essentially replaces the old methodology used to determine the Medicare Physician Fee Schedule. This methodology, the Sustainable Growth Rate formula, threatened to impose payment cutbacks for physicians for more than a decade. The QPP aims to reward the provision of high quality and efficient services through a single cohesive system that unifies and replaces several different Medicare payment programs.

In 2015, CMS announced its goal of tying 90 percent of traditional Medicare payments to quality or value by 2018.²

The QPP advances these goals and related objectives. More specifically, CMS has clarified that the QPP aims to achieve the following:

1. To improve beneficiary outcomes and engage patients through patient-centered policies.
2. To enhance clinician experience through flexible and transparent program design and interactions with easy-to-use program tools.
3. To increase the availability and adoption of robust Advanced APMs.
4. To promote program understanding and maximize participation through customized communication, education, outreach and support that meets the needs of the diversity of physician practices and patients, especially the unique needs of small practices.

5. To improve data and information sharing to provide accurate, timely and actionable feedback to clinicians and other stakeholders.
6. To ensure operational excellence in program implementation and ongoing development.³

QUALITY PAYMENT PROGRAM

The QPP, which commenced on January 1, 2017 and is anticipated to continue through 2022 and beyond, will result in negative, neutral and positive adjustments to physician compensation. CMS refers to 2017 as a transitional year for the final rule and anticipates a ramp-up period as clinicians adjust to the QPP. Note, however, that, although the reporting periods commence during 2017, physicians will not receive increased reimbursement under the QPP until 2019. For this reason, participation in the QPP should be viewed as a long-term investment.

The QPP provides physicians with the ability to choose from one of two options: (1) the Advanced APMs and (2) the MIPS. It's important for physicians to understand their options and find the best QPP track for their particular practice.

ADVANCED ALTERNATIVE PAYMENT MODELS

CMS anticipates that up to 120,000 clinicians will participate in the Advanced APM track during the 2017 performance

¹ 81 Fed. Reg. 77008 (Nov. 4, 2016).

² <https://www.hhs.gov/about/news/2015/01/26/better-smarter-healthier-in-historic-announcement-hhs-sets-clear-goals-and-timeline-for-shifting-medicare-reimbursements-from-volume-to-value.html>.

³ https://qpp.cms.gov/docs/QPP_Executive_Summary_of_Final_Rule.pdf.



year. Advanced APMs must satisfy certain criteria. They must:

- Be CMS Innovation Center models, Shared Savings Program tracks or certain federal demonstration programs
- Use certified electronic health record (EHR) technology
- Base payments for services on quality measures comparable to those in MIPS
- Be a Medical Home Model expanded under CMS Innovation Center authority or require participants to bear more than nominal financial risk for losses

As this article is being written, CMS anticipates that the following models will be Advanced APMs for the 2017 performance year:

- Comprehensive End-Stage Renal Disease Care Model (two-sided risk arrangements)
- Comprehensive Primary Care Plus (CPC+)
- Medicare Shared Savings Program, Track 2
- Medicare Shared Savings Program, Track 3
- Next Generation Accountable Care Organization (ACO)

The list of participating Advanced APMs will change over time and updates will be posted on the CMS website.

Note that the QPP does not change the Advanced APMs, but rather, offers additional incentives for sufficiently participating in them. In the event that a practice receives 25 percent of Medicare covered professional services or sees 20 percent of its Medicare patients through an Advanced APM during 2017, then such practice will earn a five percent Medicare incentive payment during 2019.

MERIT-BASED INCENTIVE PAYMENT SYSTEM

CMS anticipates that most clinicians will participate in MIPS instead of the Advanced APM track, at least initially. The agency expects up to 500,000 clinicians to participate in MIPS during the 2017 performance year and that 90 percent of eligible clinicians will receive a neutral or positive payment adjustment.

The MIPS track is available not only to physicians but also to physician assistants, nurse practitioners, clinical nurse specialists and certified registered nurse anesthetists who bill more than \$30,000 per year to Medicare and provide care to more than 100 Medicare patients per year.

The MIPS track replaces three Medicare programs: (1) the Medicare EHR Incentive Program (Meaningful Use); (2) the Physician Quality Reporting System (PQRS); and (3) the Value-Based Payment Modifier. Accordingly, the requirements for participating in MIPS are familiar to many physicians.

Performance Categories

For 2017, there are four weighted performance categories:

1. Quality (which replaces the PQRS and carries a 60 percent weight)
2. Improvement Activities (a new category that carries a 15 percent weight)
3. Advancing Care Information (which replaces the Medicare EHR Incentive Program and carries a 25 percent weight)
4. Cost (which replaces the Value-Based Payment Modifier but is not counted in the composite score until 2018)

CMS encourages clinicians to submit measures and activities in the quality, improvement activities and advancing care information categories in order to

achieve the highest possible composite score. (When the cost measure becomes a part of the composite score in 2018, no reporting will be required because it will be calculated based on claims submitted.)

Specific measure-related and reporting requirements, exceptions and nuances will differ based on various circumstances. An abundance of additional information regarding the potential quality and advancing care information measures and the improvement activities can be found on the [QPP website](#). This article covers some basic information.

Quality

For purposes of the quality category, most MIPS participants will need to report up to six quality measures (to the extent such measures are applicable), including an outcome measure, for a minimum of 90 days. Quality measures will be determined on an annual basis. For 2017, the anesthesiology measures are as follows:

- Anesthesiology Smoking Abstinence
- Coronary Artery Bypass Graft (CABG): Preoperative Beta-Blocker in Patients with Isolated CABG Surgery
- Documentation of Current Medications in the Medical Record
- Perioperative Temperature Management
- Post-Anesthetic Transfer of Care Measure: Procedure Room to a Post-Anesthesia Care Unit (PACU)
- Post-Anesthetic Transfer of Care: Use of Checklist or Protocol for Direct Transfer of Care from Procedure Room to Intensive Care Unit (ICU)
- Prevention of Central Venous Catheter (CVC)-Related Bloodstream Infections

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- Prevention of Post-Operative Nausea and Vomiting (PONV): Combination Therapy
- Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented

Improvement Activities

The MIPS measure for improvement activities will require most participants to attest that they completed up to four improvement activities for a minimum of 90 days. Groups that are located in a rural or health professional shortage area or with 15 or fewer participants will need to attest that they completed up to two activities for a minimum of 90 days.

Advancing Care Information

For the 2017 transition year, participants may select from one of two sets of measures based on their EHR. Subject to certain exceptions, the MIPS advancing care information category requires that

participants report on at least the following required categories for a minimum of 90 days:

- Security Risk Analysis
- Electronic Prescribing
- Patient Electronic Access
- Send Summary of Care
- Request/Accept Summary of Care

Reporting and Adjustments

Participating clinicians may start collecting performance data anytime between January 1, 2017 and October 2, 2017. Note that performance data must be submitted by March 31, 2018 irrespective of the specific starting date. Similar to the Advanced APMs track, the first payment adjustments (which may be increases, decreases or neither) under MIPS will not occur until 2019.

Figure 1 briefly summarizes how practices will receive increases and decreases in Medicare payments during 2019 based on their 2017 participation.

In summary, for clinicians who select MIPS, three levels of reporting will avoid a negative MIPS payment adjustment. Clinicians can avoid a downward adjustment though the submission of a minimal amount of 2017 data (e.g., even one quality measure or improvement activity). Positive adjustments will be based on the actual performance data within the reported information and not on the amount of information submitted or the length of time for which such information is submitted.

For clinicians who submit MIPS data as an individual, the payment adjustment will be based on individual performance. Such individual data for the MIPS categories described above may be submitted through an EHR, registry or Qualified Clinical Data Registry (QCDR). Quality data may also be submitted through the Medicare claims process.

For clinicians who submit MIPS data through a group, the group will receive a single payment adjustment based on the group's performance as a whole. Group-level data may be submitted through the CMS web interface (if the group registers by June 30, 2017) or third-party data submission services (e.g., a certified EHR, registry or QCDR). In future years, the federal government intends to permit clinicians to participate in MIPS through virtual groups and will propose further policies in such regard after soliciting additional input.

PRACTICAL GUIDANCE AND NEXT STEPS

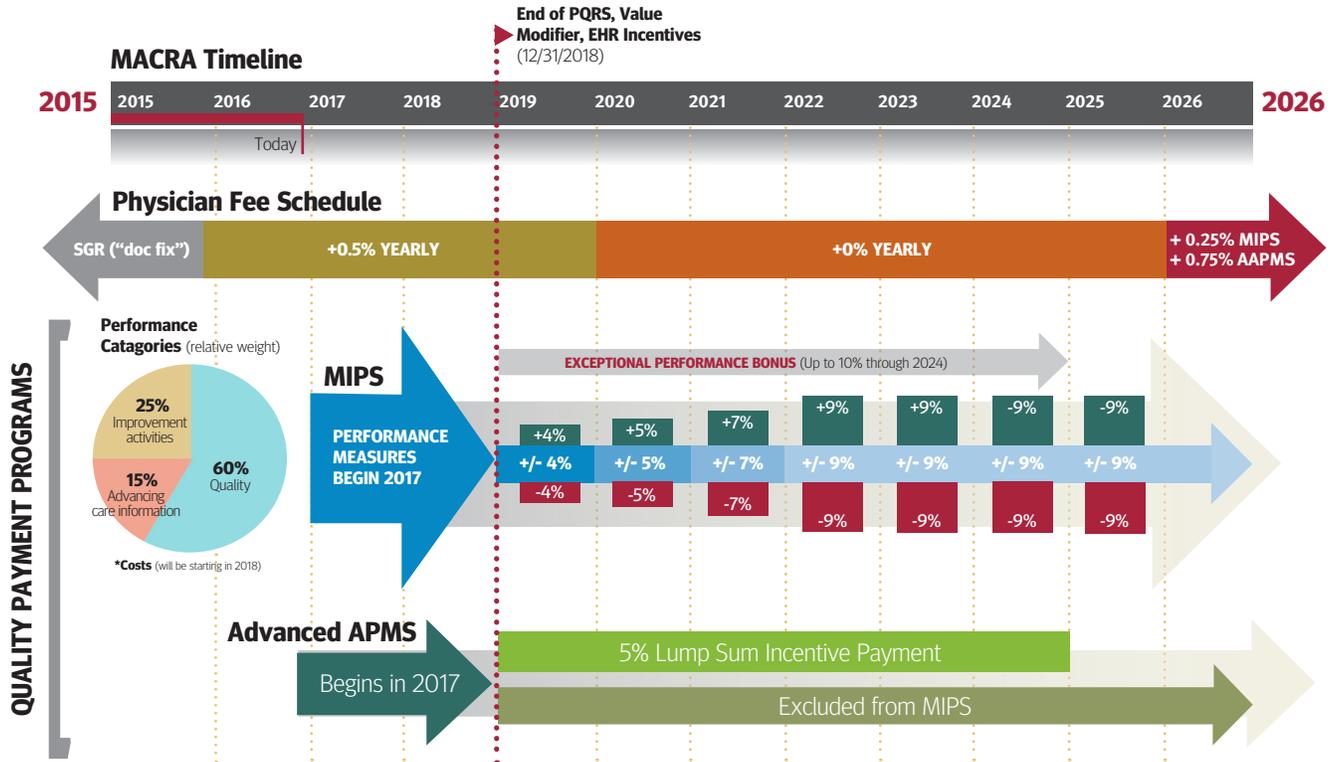
Physicians and their groups should promptly and proactively develop a strategy to thrive under MACRA and the QPP. If you participate, you need to determine which track is best (i.e., APMs or MIPS) based on your individual circumstances. Such determination

FIGURE 1 How Practices Will Receive Increases and Decreases in Medicare Payments

2017 Participation	2019 Adjustment
No submission of data	Four percent negative payment adjustment
Minimum amount of data (i.e., one measure in the quality performance category, one activity in the improvement activities performance category or report the required measures of the advancing care information performance category)	Avoid downward adjustment
90 days of 2017 data (including more than one quality measure, more than one improvement activity or more than the required measures in the advancing care information performance category)	Neutral or small positive payment adjustment
Full year of 2017 data	Potential moderate positive payment adjustment up to four percent, and potential 10 percent adjustment for high performers



Timeline of Key Dates for Implementation



Source: Day Health Strategies, 2016

should take into account whether your practice already participates in an Advanced APM or whether such participation in the future is desirable. If you select the MIPS track, you will need to decide whether to participate as an individual or a group, the level and timing of participation, and the type of reporting that is practicable.

CMS recommends that physicians take the following steps to prepare for MIPS in 2017:

- Check that your EHR is certified by the Office of the National Coordinator for Health Information Technology. If it is, it should be ready to capture information for the MIPS advancing care information category and certain measures for the quality category.
- Consider using a QCDR or a registry to extract and submit your quality data.

- Use the QPP website to explore the MIPS data your practice can choose to send in. Check to see which measures and activities best fit your practice.

The federal government offers resources to assist small practices through the Transforming Clinical Practice Initiative and through certain small, rural and health professional shortage area exceptions. Additional resources are available through governmental guidance, professional associations, consultants, software, technology and practice management companies, attorneys and others.

Additional QPP resources are available at the following sites:

- <https://qpp.cms.gov/>
- <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS->

[and-APMs/MACRA-MIPS-and-APMs.html](#).

- www.ama-assn.org/MACRA
- <http://www.asahq.org/quality-and-practice-management/macra>
- <https://innovation.cms.gov/initiatives/Transforming-Clinical-Practices/>

Good luck. You can do this.

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HOPE IS NOT A STRATEGY: HOW TO CREATE YOUR STRATEGIC BUSINESS PLAN

Will Latham, MBA

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In the previous issue of *The Communique* (“Hope Is Not a Strategy: A Primer for Anesthesia Groups on Strategic Planning,” Fall 2016) we described the need for strategic planning and described the overall process. This process includes:

1. Developing mission and vision statements for the group.
2. Identifying internal strengths and weaknesses and external opportunities and threats.
3. Discussing key issues.
4. Developing objectives and strategies.
5. Creating action plans to implement those strategies.

Let’s now turn to the “nuts and bolts” of how your anesthesia group can conduct a successful strategic planning process.

RETREAT VS. SERIES OF MEETINGS

Anesthesia group strategic planning meetings provide an opportunity for the physicians to discuss key issues and develop plans for the group.

The meeting process typically comes in one of two forms: (1) a retreat; or (2) a series of meetings.

We believe that a retreat approach is the preferable process for the following reasons:

- With a series of meetings, you will chew up a lot of time reorienting everyone to what you are doing and what has been decided.



- Often, the attendee mix changes from meeting to meeting, the result being that the group zig-zags in its decision making.
- Typically, groups conduct these meetings in the evening, which is when the physicians also tend to be tired or stressed. The result is that discussions often turn to the same subjects discussed at the group’s regular meetings.

A strategic planning retreat might last one to two days, depending on the issues to be addressed and the time the physicians are willing to give to the process.

PREPARING FOR THE RETREAT

It is essential to use the time spent at a retreat in the most efficient and effective manner possible. Why?

- Most managers and group leaders know that it’s hard to pull all the physicians together. When you have them together, you want to make the most of it.
- The most expensive part of the process is the time at the retreat. If you multiply the number of people in the room by an hourly rate for an eight-hour day, you end up with a large number. For example, if you have 20 people in the room, eight hours at an hourly rate of \$300 would cost \$48,000.

Retreat time needs to be structured to be as efficient and effective as possible. That’s why preparation is key.

Preparation involves considering the following:

1. Who will be the participants?
2. What will be the timing of the meeting?



3. Who will serve as the retreat facilitator?
4. What data/information will be needed for the meeting?
5. What are the key issues?
6. What is the agenda?
7. What other arrangements are needed?

We will cover the first two items—participants and timing—in this article and the remaining preparation steps in future articles.

PARTICIPANTS

Who should attend the anesthesia group's strategic planning retreat? Typically, attendees should include all shareholder physicians and the group's manager. Depending on your group's situation, you might also consider:

- Shareholder-track physicians
- Employed physicians
- Selected mid-level providers
- The group's CPA
- Other advisors

Typically, we recommend the following:

- The group should limit the number of attendees, especially those who are more likely to be “observers” (such as members of the administrative team beyond the manager, employed physicians or mid-level providers). You want the physicians to have a free and open discussion about the issues. Sometimes physicians “clam up” if too many non-shareholders are in the room.
- If you include non-shareholder physicians, you might want to consider having a “shareholder-only” segment.

TIMING

You will need to agree on the timing of the meeting—both when will it be held and how long the retreat will last.

Most anesthesia groups conduct their retreats over a weekend. If the group plans to allocate one and one-half days to the process, often, it allocates a full day on Saturday and a half-day on Sunday.

The group should pick a time when most, if not all, of the physicians can be present. However, every group has some who are more involved and vocal than others. The timing should be planned to make sure these engaged physicians attend. If you try to avoid the “nay-sayers,” they will use that as an excuse to resist implementing the plan.

Logic would say the retreat should be held in the fall so that once it is complete, management can develop the annual business plan and budget, and implementation can begin in January. However, we find that most groups conduct their retreats on weekends in January through April to avoid holding the retreat on weekends during nicer weather.



AGENDA

Once the preceding steps have been taken it is time to put together the meeting agenda. Your agenda might look like this if you are conducting a one and one-half or two-day retreat.

Saturday

- Meeting goals and ground rules
- Decision making
- Interview feedback:
 - Internal analysis – strengths and weaknesses
 - Environmental analysis – opportunities and threats
- Mission and vision statement
- Discuss key strategic issues

Sunday

- Discuss key strategic issues, continued
- Next steps in strategic planning process
- Summary

As you can see, the retreat includes some introductory work related to meeting goals, ground rules and decisions; feedback from the interviews; and the work of defining the mission and vision and discussion of key strategic issues.

OTHER ARRANGEMENTS

You also need to make some detailed arrangements about where the meeting will be held. We typically recommend a meeting room at a hotel. Hotels are usually set up to host meetings and can provide meal services. Meeting at the hospital is typically a bad idea as hospital meeting rooms are not conducive to a group meeting, and many hospitals don't offer food service on weekends when meetings are typically held.

Some groups hold their retreats out of town and use meals and evenings to

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HOPE IS NOT A STRATEGY: HOW TO CREATE YOUR STRATEGIC BUSINESS PLAN

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build camaraderie. While this can be a good idea, some physicians are resistant to traveling. You will need to determine your group's willingness to travel.

If you do decide to hold the meeting out of town, we suggest that you do not make it a "family outing." Family outings have two downsides: (1) reduced time for camaraderie-building and physician-to-physician interaction; and (2) increased anxiety among some physicians to complete the retreat work as fast as possible to spend time with their families.

You will also need to make a final decision as to how long you will meet. As noted earlier, the length of the meeting depends on two things:

1. The issues to be covered
2. The amount of time the physicians are willing to give to the planning process

If they are only willing to give one day, you will need to prioritize your key issue list to make sure the most important issues are covered. You will also need

to make sure the meeting room is set up in the way you like (we typically suggest a U-shaped table set-up) and has flipcharts available to record discussion points and decisions, and that you arrange for any needed handouts.

COMMUNICATION ABOUT THE RETREAT

The last task in preparing for your retreat is developing a memo and sending it and the agenda to the participants.

The memo package should:

- Describe strategic planning and tell why it is important.
- Discuss the goals of the retreat.
- Include details of the retreat (where and when).
- Include the agenda.
- Include important background information related to specific issues (cost benefit analysis, etc.).
- Include articles about the future of healthcare. Underline or highlight the important passages.

STRATEGIC PLANNING FOR LARGER GROUPS

Once a group grows to a certain size (e.g., 25-30) it becomes increasingly difficult to conduct a planning retreat that meets the following criteria:

1. All physicians attend the retreat.
2. There is an in-depth and complete discussion of the important issues.

The problem is group processes. With 50 people in the room, it is nearly impossible to have a complete debate and discussion that includes all members. What often happens is that five or six individuals debate the issues while everyone else watches.

If you *must* have all of the physicians in the room, these problems can be mitigated by:

1. Using the retreat as an information-sharing only meeting
2. Using subgroups to discuss issues
3. Using a rigorous process to discuss and debate motions that were developed prior to the retreat

We have used the following approach for large group strategic planning efforts that balance the desire for involvement with the ability to have beneficial in-depth discussion on the issues.

Step 1: Survey/Interviews

Typically, all physicians are surveyed to obtain their input on:

- Group strengths and weaknesses
- Opportunities and threats the group faces





- How group members would like to see the group evolve
- The issues that should be addressed during the planning process
- Other questions that the group would like to ask

In addition to the surveys, we typically conduct individual interviews with those who will attend the “Board+” Retreat (discussed below).

Step 2: “Board+” Retreat

A subset of the group then meets to discuss key issues and develop plans for the group. Typically this group is composed of the board and other key leaders. It is best to keep this group to 15 or fewer. The meeting typically lasts one to two days, with one and one-half days being the most common. This group develops what we call the “draft” plan for the group. At this meeting the attendees:

1. Develop or update the group’s mission/vision
2. Review environmental opportunities and threats
3. Discuss internal strengths and weaknesses
4. Create clear goals and objectives
5. Work to resolve key issues facing the group

Subsequent to the retreat, a draft plan is developed that is a written summary of the conclusions reached at the retreat.

Step 3: Full Group Meeting

Following the Board+ Retreat, a meeting of all physicians is conducted and the results of the planning retreat presented. At this time, all physicians will be able to give their feedback about the results of the planning process.

This step is usually completed at an evening dinner meeting. It is important to note that the goal of this step is not to re-do the work of the retreat. Instead, the larger group is asked three questions:

3. What key issues were not adequately addressed in the draft plan?

Operationally, the physicians sit at small tables of six or so, with at least one person at each table who attended the retreat. You should try to spread out the “nay-sayers” to prevent negative momentum.

Once again, this meeting is to allow the shareholders to have one more chance to provide input into the planning process.

Step 4: Board Adoption

At a board meeting the board members review the results from the full group meeting and decide whether the draft plan should be adjusted. The final plan is then adopted by the board. This process balances the need for input, in-depth discussion and decision-making. ▲

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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 wlatam@lathamconsulting.com.



SWITZERLAND AND THE ANESTHESIA GROUP STRUCTURE

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Quick! Who's the president of Switzerland?

Anesthesia group leaders seeking to create a larger structure out of existing groups, from an alliance among local groups, to business models for exclusive contracting, to the creation of a true regional or national player, encounter a plethora of problems from the merely difficult (e.g., due diligence) to the moderately troublesome (e.g., power and control) to the pure bottom line (e.g., purchase price).

Those thinking across state lines face a patchwork of laws and regulations governing structure and ownership which creates a sometimes-impermeable barrier to achieving their goal. Yet group leaders generally confine their thinking to the creation of either a fully integrated structure such as a corporate or partnership-type entity, on the one hand, or a loose, separately owned management services organization (MSO)-type structure, on the other hand.

But there are other ways of devising medical group business arrangements, whether purely within a local area, within a single state or across state lines, and Switzerland provides an example.

So, back to the question about the president of Switzerland. Don't know who he is?

Well, in all honesty, there's little reason to know, even if you live in Switzerland, because the president of Switzerland is neither the head of government nor the head of state. His function is to break a tie vote. You see, Switzerland is a federation of self-governing cantons, whose representatives together form a collective governing body.



Which leads us to a Swiss business structure that mirrors this notion of self-governing entities holding themselves out to the world as unified: the "verein" (pronounced "FAIR-ein" and rhymes with "FAIR wine"). A verein is a confederation-type entity, like a partnership of professional corporations or professional associations, *but also very unlike a partnership.*

NOT A PARTNERSHIP

In a partnership, the partners conduct a unified business, with each partner having joint and several liabilities. In other words, Partner "X" is liable for the obligations of the partnership even if those obligations were incurred by Partner "Z." And that's still the case if X and Z are themselves medical corporations or professional associations.

So, if Big Entity Partnership, with partner entities in Los Angeles, San

Diego, Austin and Allen, is slapped with a \$100 million judgment arising from one practice site, the bank accounts of each partner entity are at risk.

In a verein, however, even though the overall organization itself presents a unified structure to the outside world, for example, "Medical Associates of the United States," each of the members is an independent business entity and is not liable for the overall organization's debts. And in similar fashion, no member is liable for the debts of any other member. Therefore, a fictitious "Medical Associates of Canton, New York" is not liable for the debts of the overall "Medical Associates" verein or for the debts of another member, say, "Medical Associates of Canton, Massachusetts." The lack of cross-liability frees the organizers from many of the problems encountered in creating alignment between medical groups.

There's a dramatically lessened need to conduct due diligence as to a potential constituent entity's formation history, finances, known and potential liabilities, and so on. Those concerns are major issues in creating a customary business structure and certainly in any traditional merger or acquisition where the financial and business condition of the target entity impacts the purchase price as well as the desire to do the deal at all.

Because no revenue or profit sharing is typically involved in a verein structure because the verein itself does not engage in business (although there can be a functional equivalent, which is a complex issue outside the scope of this article), there's no need to bring all of the constit-

uent groups and their physicians into a common compensation plan. Matters of compensation, just as matters of profit and loss, and management and control of the local vehicle, can remain exactly as before.

Additionally, because the constituent entities continue to legally exist both before *and after* joining in the *verein* as operating entities, there is no cross-state-border restraint on the form of legal entity. In other words, *verein* members can continue to practice as professional associations in states such as Texas that recognize that form, as well as in states such as California that do not recognize the professional association form but in which *verein* members could operate as medical corporations (which, in turn, are not recognized in Texas).

As an aside, note that just as a *verein* is agnostic as to the *form* of legal entity adopted by the constituent members, it's also agnostic to the profession/licensure of the individuals practicing via the constituent members. Therefore, cross-specialty, cross-licensure or even licensed/non-licensed business combinations are within the realm of *verein* structure.

It is important to note that the *verein* structure lowers the barrier of "trust to entry." It's far easier to trust in a vision if it doesn't require giving up your ownership and local control, *and* becoming liable for someone else's debts.

NOT AN MSO

Just as is the case with a partnership, a *verein* shares similarities with an MSO structure. However, there are major differences.

An MSO, in the context of the business of anesthesia, is an entity that is often owned by a third party (e.g., a billing service that has expanded to a broader role) that exists to provide management services to independent



medical groups. Those groups generally don't hold themselves out as being affiliated. They generally don't do business under a common brand. In fact, doing so within the context of an MSO presents a significant risk of creating cross liability both among the co-branded independent "clients" of the MSO as well as on the part of the MSO for one or more of its clients.

A *verein* has no owners. Instead, it is an umbrella-like entity comprised of its independent group members, providing a common brand to share marketing, high-level strategy and so on.

CONCLUSION

The point of this article isn't that you should organize or reorganize your multi-component medical group as a *verein* or rush to set up an umbrella entity in that fashion (although it warrants consideration). Rather, it's that there are additional conceivable forms for top-level entity organization other than simply partnerships or corporations.

Many of these structures, such as *vereins*, can be useful as a first step toward tighter integration as well as for final destinations.

Although alliance type structures in healthcare come with a set of unique compliance issues, from antitrust to anti-kickback and Stark, and, as a result, are often suspect, with the correct strategy and structuring they present a world of opportunity, whether within a single specialty or, perhaps more interestingly, among multiple specialties, and across the bounds of professional services and facilities and beyond. ▲

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THE ACA'S IMPACT ON HEALTHCARE PAYMENT

Maurice Madore, MBA, CPC

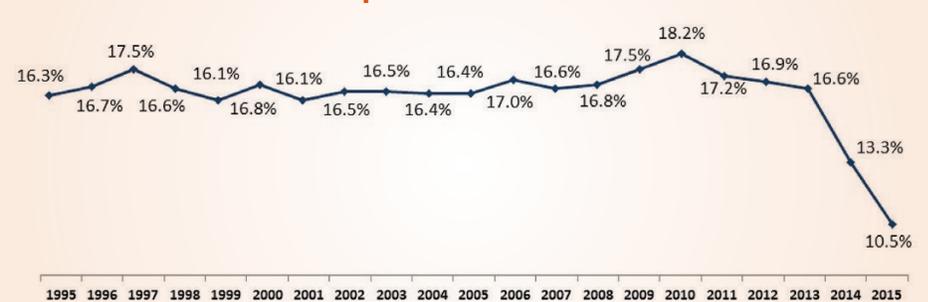
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When the Affordable Care Act (ACA) was signed into law in 2010, it set into motion a series of intended and unintended actions and consequences that, after several years, can now be reviewed and interpreted. According to the Centers for Disease Control and Prevention, the number of uninsured in the United States has decreased from 15.7 percent in 2009, at the height of the most severe economic downturn in recent U.S. economic history, to about 9.1 percent in 2015.

While millions of people have gained coverage under provisions of the ACA that went into effect in 2014, over 28 million nonelderly individuals remained uninsured in 2015. Many of these people are ineligible for ACA coverage, either because of their immigration status or because their state did not expand Medicaid. Others may be eligible, but do not know of the new coverage options, have had difficulty navigating the enrollment process or have opted not to enroll. In addition, affordability, even with the availability of tax credits, remains a barrier for many. Uninsured adults continue to name cost as a major reason for remaining uninsured.¹ The increase in the number of insured Americans was an intended impact of the ACA. But the ACA has had some unintended consequences as well. Hospitals and providers have been forced to restructure how they get paid for services as patients have become responsible for a higher percentage of their healthcare costs. Employers have offered more high deductible health plans (HDHPs) and fewer traditional policies. A look at the types of plans that many of us have personally chosen in our own places of employment verifies that this trend is

FIGURE 1

Uninsured Rate Among the Nonelderly Population, 1995-2015



Source: CDC/NCHS, National Health Interview Survey, reported in http://www.cdc.gov/nchs/health_policy/trends_hc_1968_2011.htm#table01 and <http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201605.pdf>.



real. In 2009, only about eight percent of employer-sponsored plans were of the HDHP variety. By 2015, that percentage had risen to 24 percent, according to *Health Affairs*.²

THE RISE OF HIGH DEDUCTIBLE HEALTH PLANS

According to Towers Watson,³ in order to reduce their healthcare costs, 52 percent of employers now offer at least one type of HDHP and 22 percent offer only HDHPs. Many employees opt into these plans because of the significantly lower premiums. However, what many fail to consider is the high deductible that they will need to cover. Out-of-pocket healthcare costs have increased by 230 percent since 2009.

This increase in patient responsibility has important implications for providers. It was assumed that increasing patient responsibility for healthcare costs would lead to “shopping” by patients for low cost/high quality services. The reality of the shift from a traditional model to a shared cost model has been much different. Preliminary data show that employees with HDHPs are reducing their healthcare expenditures—but not because they have found lower cost/higher quality services. Rather, the reductions in healthcare expenditures are more closely related to the tendency among a growing number of individuals to delay care and to delay treatment during the early stages of illness. Although long-term data is not yet available, studies

¹ Kaiser Family Foundation analysis of the 2015 National Health Interview Survey, <http://kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/>

² Islam, Ifrad, “Trouble Ahead for High Deductible Health Plans,” *Health Affairs Blog*, October, 7 2015, <http://healthaffairs.org/blog/2015/10/07/trouble-ahead-for-high-deductible-health-plans/>

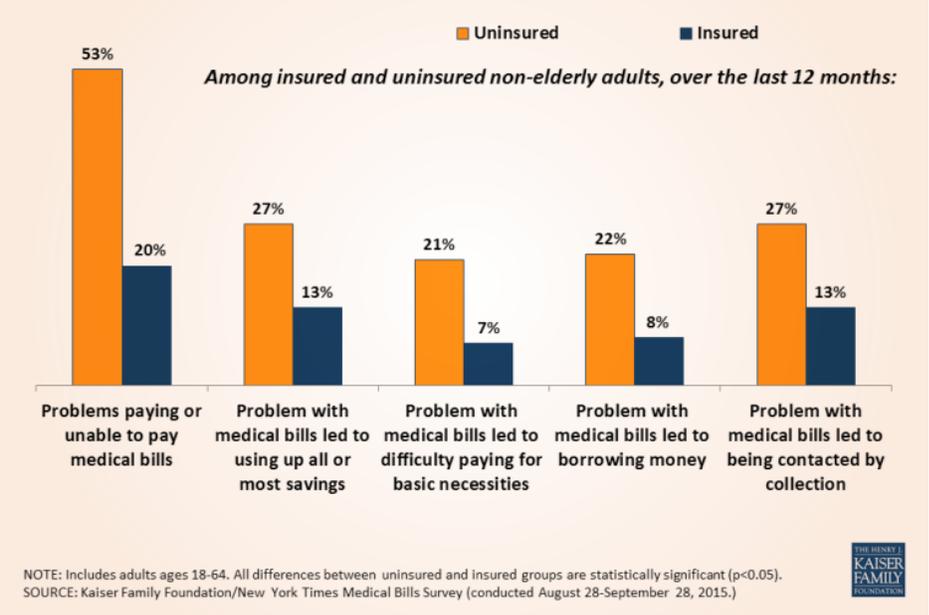
³ Brandelsky, Karen, “The Hidden Risk of High Deductible Health Plans,” *Time/Money*, November 3, 2015, <http://time.com/money/4091524/health-insurance-high-deductible-plans-risk/>



by the National Bureau of Economic Research (NBER) give early indication of some interesting trends.

NBER followed several companies offering HDHPs to employees to examine how employees handle larger responsibility for their own healthcare costs. Employees were considered affluent, with median annual incomes of \$125,000 to \$150,000. The companies also provided financial assistance through health savings accounts (HSAs). Even with additional financial support, employees sought fewer services. Colonoscopies and mammograms decreased by 32 percent and nine percent, respectively, compared with previous periods when employees had access to low deductible plans. The researchers concluded that the behavior in this small sample might signal an emerging trend among employees with HDHPs who are shouldering a significantly larger portion of their healthcare costs. This shift in behavior could have long-term public health consequences. As more patients opt out of early screening and treatment, even for covered services, they will find themselves dealing with more serious illnesses and greater medical expenses.

FIGURE 3 Problems Paying Medical Bills by Insurance Status, 2015



THE BAD DEBT DILEMMA

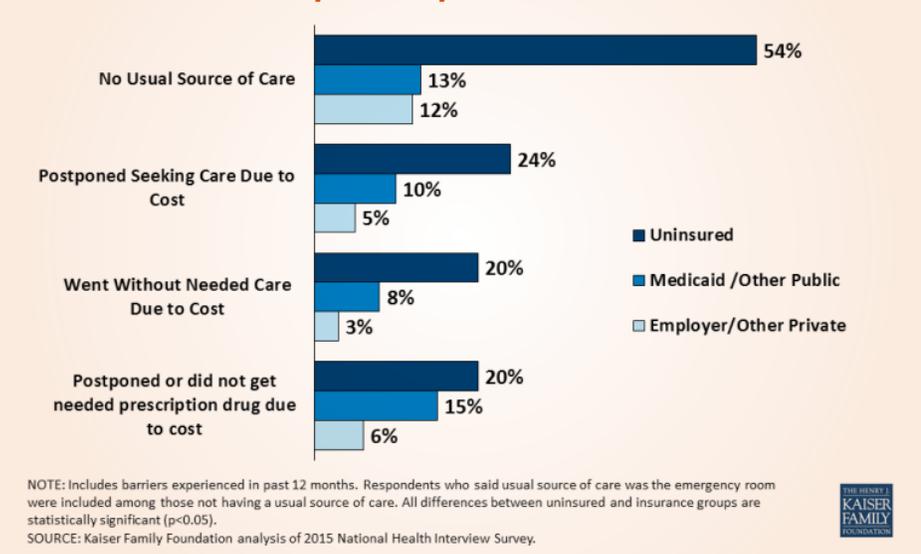
As the percentage of patients covered by these types of plans increases, the challenge to providers of collecting payments from patients will grow as well. PricewaterhouseCoopers (PwC) has estimated that in the next few years 44 percent of employers will offer only

HDHPs—a 74 percent increase from 2010. Add enrollees in the federal and state-run marketplaces, in which HDHPs are the most popular type of plan and in which patients are responsible for as much as 30 percent of their healthcare costs, and it becomes clear that the industry is undergoing a major shift in how providers and hospitals are paid.

More data on this new paradigm comes from the hospital sector. Before 2011, the majority of payments collected by healthcare systems were from insurance companies and government agencies. In 2014, payments collected from patients had risen by 193 percent. It's a number that can't be ignored. And it tells only half of the story. The other half relates to the enormous amount of money that healthcare organizations and practices are not collecting from patients. More patients have not been paying their balances. These unpaid balances become bad debt.

A report from the American Hospital Association notes that more than \$502 billion in uncompensated care—\$33

FIGURE 2 Barriers to Health Care Among Nonelderly Adults by Insurance Status, 2015





THE ACA'S IMPACT ON HEALTHCARE PAYMENT

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billion annually—has been delivered since 2000.⁴ This number is expected to grow as health systems continue to experience increases in bad debt. According to McKinsey & Company, bad debt has increased by 30 percent since implementation of the ACA.

NEW COLLECTION STRATEGIES

The dual trends of increased patient responsibility and increases in unpaid balances have put a large financial strain on hospitals and physicians that has forced them to develop new revenue cycle management strategies. Some hospitals are creating teams of specialists to help patients identify their financial responsibilities before admission with the goal of securing some prepayment for elective care. However, the trend among patients to delay care has led to an increase in emergency department visits that hinders careful financial screening of patients before admission. In addition, emergent patients often receive out-of-network care. The inability, in these instances, to collect payment upfront increases the chances that these balances will not be paid.

Office-based physicians are trying some of the same strategies, including attempting to collect a portion of patient balances up front. Hospital-based specialties, including anesthesia, radiology and pathology, have limited opportunities to conduct these financial reviews because many services are not clearly defined prior to the delivery of care. A surgical patient may be under anesthesia longer than expected due to

complications, or may need intraoperative x-rays or a pathology report. These patients may be unwilling to pay for additional services that exceed original estimates.

In an attempt to manage the revenue cycle, hospitals have developed revenue cycle management processes that focus on getting a clean claim to the carrier for processing. Some organizations focus on ensuring that claims are processed in a timely manner and that patients with high deductibles are processed when the carrier, rather than the patient, is responsible. This process was highly effective several years ago, when average deductibles were relatively low. As deductibles have risen, some providers have begun holding charges for longer periods, hoping to receive payments from carriers. This strategy has led to a practice among many providers of sending claims to patients much later in the billing cycle following the delivery of services—a practice that has led to patient complaints and increases in dissatisfaction. Billing company professionals, hospital administrations and group practice management staff have been carefully reviewing data and payment patterns in order to adapt to the changing environment and develop effective strategies.

CONCLUSION

In conclusion, hospitals and providers have had to change their billing and collection practices to adapt to major changes in the health plan market. More Americans are insured, but more are carrying HDHPs. The shift of more financial responsibility to patients has led more patients to defer care in order to avoid out-of-pocket costs and has increased bad debt among hospitals and providers.

The provision in the ACA for a “Cadillac tax” penalizing employer-sponsored plans likely would force more employers to offer HDHPs in order to avoid the tax. However, president-elect Trump’s promise to repeal the ACA has lessened the likelihood of that tax becoming a reality. Are we looking at another 2,000-page document to replace the 2,000-page document that we currently have? Rest assured that whatever the lawmakers in Washington draft, it will be a journey into the unknown. As healthcare professionals, we will be challenged to create a process that ensures payment from insurers and patients. As Larry Levitt, a senior vice president at the Kaiser Family Foundation, said in the *Washington Post*: “The Affordable Care Act, enacted in the spring of 2010 with virtually no GOP support, is a 2,000-page statute that has ushered in the broadest changes to the healthcare system in half a century. With Trump’s election, the ACA as we know it would seem to be toast.”

Only time will tell whether this will happen, and if it does, what the replacement package will look like. 

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⁴ American Hospital Association, Uncompensated Hospital Care Cost Fact Sheet, January 2016, <http://www.aha.org/content/16/uncompensated-carefactsheet.pdf>



ELECTRONIC MEDICAL RECORDS IN ANESTHESIA: WHO WILL BENEFIT AND HOW?

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The concept of automating the anesthesia record has intrigued academicians for decades. Some of the early versions of software packages for computer-based record keeping were quite complete and impressive despite the technology's limitations during the 1980s and 1990s. A number of companies made significant investments in the various software options. There was only one problem: they simply were not selling.

While the proponents' arguments could be compelling, there was no demand. The solution was way ahead of its time, and it would take a combination of regulatory initiatives and market changes for the time to be right. Even now that market conditions are more favorable, implementation continues to be a slow and ponderous process. Understanding why this is sheds light on the fundamental challenges of implementing any meaningful change in the American healthcare system.

THE ORIGINS OF AUTOMATED ANESTHESIA RECORD KEEPING

It is not hard to understand what motivated the early innovators. Anesthesia record keeping has remained an arcane and manual process that relies on the provider to capture and record a wide array of data trails. The first paper records were developed in the 1890s and remain little-changed. Unlike the surgeon's operative report, which



provides a narrative description of the surgery, the anesthesia record is designed to document not only what was done to a patient during the surgical experience but also how the patient responded. Even a cursory review of a completed record makes one wonder if there is a meaningful correlation between what actually happened in the operating room and what got documented. Not only is much of the information filled in after the fact from memory, but as the writer of the history of the case, the anesthesia provider will tend to write the story based on how it ended and discount any adverse events or inconsistencies that may have occurred during the case.

Not only are anesthesia records an imperfect form of record keeping of a reasonably complex interaction of surgical procedure and pharmacological management, but they are also a poor tool for research and analysis. The details and data elements are captured in a

format that is impossible to review except by means of a tedious manual audit. If one wanted to compare aspects of case management for a given surgical procedure one would have to identify, pull and review a sample of records prepared by different providers, which would prove incredibly time-consuming and which would probably reveal more inconsistencies in record keeping than in clinical care. Not only is most physician handwriting nearly illegible, but often what is being reviewed are carbon copies which are even harder to interpret.

As the anesthesia record has evolved, it has become a significant document on a number of levels. Initially designed as a medical record and communication tool, it has become a medical-legal document that may be used to demonstrate that standards of care were met in the care of patients who may have had adverse outcomes. As the specialty has striven to improve the quality of care provided, the details of the anesthesia record have come to be useful for a variety of quality assurance projects. Increasingly, the template is intended to ensure that critical details of intraoperative management are consistently monitored and recorded. The American Society of Anesthesiologists (ASA) has played a key role in defining the categories of information that should be documented for each case. In many ways the anesthesia record is a reflection of the evolution of the specialty.

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What the early developers of anesthesia record-keeping software saw was a significant opportunity to use technology to accomplish what they believed were three notable shortcomings of standard anesthesia record keeping:

- Lack of consistency and legibility in the way the anesthetic experience was being documented;
- Inconsistency in the way in which physiological data was captured and recorded; and
- A general inability to review and research clinical trends.

It was not until the 1980s that the first automated anesthesia record systems appeared on the market. One of the first was CompuRecord, which is still available today from Philips. Computer technology provided a ready solution to what many perceived as a significant problem. A computer could do something the human brain could not: integrate a significant amount of data into a clearly legible format that could be saved in a digital format.

The creation of the actual record starts with an extract from the scheduling software that includes the patient name, date of service, scheduled procedure and preoperative diagnosis. This basic information is then supplemented with notes from the preanesthesia assessment and the anesthesia plan. Details of the case are captured in real-time via digital interface to the monitors. Buttons prompt the provider for standard services, which make the record keeping much easier and more consistent than a paper record. At the end of the case, the provider has an opportunity to review the details before closing the record. The result should be a true and accurate record. As computer technology improved, more features kept



being added to make the input easier and the output more complete. The inclusion of touchscreen technology represented a huge leap forward.

One of the main features of these automated records was their ability to facilitate compliance with arcane billing regulations. The need to document that an interscalene block was performed for the purpose of postoperative pain and at the request of the surgeon could be achieved with the click of a button. Such records also held the potential to allow providers to make critical coding decisions at the time of service. Most systems included a combination of hard and soft stops to remind providers of critical pieces of information.

The concept appealed to a wide variety of practices but the reality did not live up to providers' expectations. Interfacing with hospital information systems to capture the demographic and scheduling details often proved problematic. There were similar problems capturing the digital output from the monitors. Databases were not always easy to manage and mine.

PROVIDER CONCERNS ABOUT AUTOMATING ANESTHESIA RECORD KEEPING

For many years the development of automated anesthesia systems was a cottage industry that attracted anesthesia providers with a particular interest in software development. Some of the systems were adopted by companies, such as Philips, that sold anesthesia machines, but many were essentially homegrown, stand-alone systems. Most anesthesia providers recognized the paper record's limitations, but there did not seem to be a viable alternative, and most anesthesia providers tended to dismiss the limited offerings out of hand. However logical and attractive an automated record might seem, the challenge of creating a system that would work in every operating room to capture all anesthetics was overwhelming.

An informal poll of anesthesia providers would have identified three main concerns. The potential for artifact in records was a major concern. Suppose a surgeon were to lean on the blood pressure cuff during the case. The resulting uptick in blood pressure would be ignored in the manual record but be captured by the automated record. The resulting record might indicate a situation to which the anesthesia provider should have responded. Imagine if there were an adverse outcome. Artifact in the record might be difficult to explain.

The flipside of this argument suggested that since most manual records are not true reflections of what happened during the case, they would make automated records look problematic. Anesthesia had enjoyed the power of the pen in its record keeping for so long that there was considerable resistance to losing control.



Even though most programs allowed the provider to modify or edit the data displayed on the record, this argument continued to be a popular theme of resistance to automation.

For those inclined to buy into conspiracy theories, the debate over automated anesthesia records was fertile ground. What was the point of capturing all the details of each anesthetic if not to impose clinical standards on individual providers? Anesthesiologists were quick to point out that anesthesia is a specialty that does not lend itself to “cookbook medicine.”

Meanwhile, the biggest obstacle to automated records was the price tag. A typical system could cost as much as \$40,000 per anesthetizing location, which was far beyond the budget of most anesthesia practices. Ultimately, then, the decision lay in the hands of the hospital, which also had little reason to make such an investment.

And so for years, the automated anesthesia record industry sputtered along. A number of companies would bring impressive offerings to the ASA annual meeting each year, but when asked, they all had to admit there were very few working installations. Automating the anesthesia record was a concept whose time had simply not come.

REGULATORY IMPETUS TO IMPLEMENT ELECTRONIC MEDICAL RECORDS

There is a popular saying that sometimes the way to solve a problem is to create a bigger problem. This was the case with anesthesia record keeping. The solution to the challenge of financing the implementation of a full suite of automated anesthesia records came only when hospitals had to implement electronic medical records (EMRs) for all services. As one might have expected, even though the initial offerings of the enterprise solution companies were not



the ones preferred by anesthesia providers, the more systems that companies like Epic and Cerner installed, the better their systems got.

Legislation laying the groundwork for the encouragement of the use of EMRs can be traced back to President Clinton’s signing of the Kennedy-Kassenbaum bill into law in August 1996, a bill that would subsequently be referred to as the Health Insurance Portability and Accountability Act (HIPAA). This legislation laid the foundation for standards for the transmission of healthcare data and created a framework for the protection of protected healthcare information (PHI). These were necessary first steps on the path to a world where details of a patient’s care could be safely captured and transferred via the worldwide web.

In June 2004, President George W. Bush signed an executive order to provide federal leadership and national implementation of an interoperable EMR system by 2014. His order established the Office of the National Coordinator for Health Information (ONC) to lead efforts in health information technology (HIT). These actions clearly envisioned an evolution of what was primarily paper-based medical record keeping to an electronic format. While a variety of systems were being worked on, the most notable of which was being developed

by the Veterans Administration (VA), this order clearly envisioned being able to develop national standards so that various systems could communicate with each other.

Proponents of this process argued that the creation of a national database of healthcare data would create a system that would allow patients to have better access to their own healthcare information and participate in the management of their own care, as well as:

- Improve the quality of care by reducing unnecessary and inappropriate testing and errors;
- Reduce clinical paperwork;
- Give healthcare providers better access to patient chart data in a standard format;
- Improve record keeping for more efficient and accurate billing; and
- Drive down the cost of healthcare in the United States.

Because it was clearly understood that the implementation of the necessary technology would require an investment of both money and resources, a series of incentives were envisioned to encourage the meaningful use of HIT. Over time, the use of the term “meaningful use” took on a life of its own to describe the various phases and aspects of the transition to an era of electronic medical record keeping in healthcare.

The next step in the process came in 2009 when President Barack Obama signed the Health Information Technology for Economic and Clinical Health Act (HITECH) into law. HITECH authorized the ONC to develop HIT to facilitate EMR implementation. The law also envisioned providing grants and loans to healthcare providers, hospitals and other healthcare entities to implement HIT. Most providers in anesthesia have



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been actively responding to the various phases of implementation related to this. They know them as PQRS, meaningful use, QCDR and MACRA, all distinct programs to encourage HIT adoption.

Navigating the changing guidelines and regulations has been no small feat. Most practices have had to expend considerable time and effort to comply. Increasingly, each new program provides financial incentives and penalties for compliance and noncompliance. It is safe to say that when one looks at the details of each year's plan, to the extent that it is actually defined in the regulations, it is easy to lose sight of the intent of the law.

One of the fundamental challenges of implementing any change in the American healthcare economy is human behavior. There is an inherent inertia in healthcare protocols. Change tends to come slowly. Much of what we are seeing in the unfolding of the meaningful use strategy is public policymakers playing chess with healthcare providers. However, meaningful use started long before "Obamacare" and will, no doubt, persist well into the next administration.



THE REALITY OF IMPLEMENTATION

As a result of these developments, the implementation of anesthesia EMRs has been gaining momentum. Careful observers of this process, such as Anesthesia Business Consultants (ABC) (which is currently working with dozens of clients who have either just implemented an anesthesia EMR or who are in the process of doing so) note every implementation process has to overcome and address two common misconceptions about EMRs.

When a hospital or anesthesia practice selects a system from a qualified vendor, such as Epic or Cerner, two of the most common vendors, there is a tendency to think that such well-established firms have developed a comprehensive solution that can easily accommodate the average anesthesia practice. This is simply not the case. Despite the systems' features and functionality, few installations do not involve considerable modification. Nowhere is this more evident than in the implementation of anesthesia EMRs. Knowing this need for customization, ABC developed a dedicated team of EMR specialists to guide clients through the implementation process. The team's mantra: "If you have seen one Epic/Cerner implementation, you have seen one Epic/Cerner implementation."

Anesthesia practices have a preconceived notion that the EMR will simplify record keeping and streamline the submission of charge data to the billing company. Vendors often tout the potential for a direct electronic interface, but the reality is otherwise. Virtually no anesthesia practice with an EMR is able to rely on an electronic interface to transmit all cases from clinical venue to billing system. Most coding for practices using EMRs is done based on a manual review of a

digital pdf of the anesthesia record. The notion that an EMR will expedite charge submission is a fallacy. The implementation of most Epic anesthesia systems, for example, requires a three- or four-day hold on charges to ensure completeness of batches.

The selection process complicates these basic challenges. Few anesthesia practices actually choose the system they will be forced to accept. In most situations, the facility picks the system, and the facility's goals and objectives rarely align with those of the anesthesia practice. What most facilities want is an enterprise-wide solution that can accommodate all medical specialties and services; the anesthesia record option is often little more than an afterthought.

This is why the implementation process for anesthesia is so challenging—and so critical for success. Any anesthesia practice contemplating the implementation of an EMR should ask the following questions:

- To what extent will the proposed solution accommodate all aspects of the practice's services?
- How will providers get trained and what kind of support will they receive?
- How will the interface to the hospital and its scheduling program work?
- Will the provider have the ability to readily edit the details of the surgical procedure and the postoperative diagnosis?
- How will rules for hard and soft stops in record keeping be defined?
- What is the process to confirm that all cases are captured and transmitted to the billing office?



- Who will be responsible for assigning billing codes, the provider at the site of service or the coder in the billing office?
- Who owns the anesthesia data and how easy will it be for the department to mine its clinical database?
- How will requests for software modifications be handled?

This last question can be a major issue. When a hospital picks a system and enters into a contract with the vendor, it is usually based on a limited budget. The anesthesia department's functional requirements must be agreed to up front. Anesthesia must be involved early and interact regularly with the developer and vendor. To facilitate this process, the ABC EMR team has developed an extensive list of features and functionalities essential for most practices.

THE FUTURE OF ANESTHESIA ELECTRONIC MEDICAL RECORDS

Clearly, the time has come for EMRs in anesthesia. Before long, any practice that has not implemented an EMR will be considered a dinosaur. As the percentage of anesthesia practices with automated records increases, the state of the industry improves. Each version

of each system offers more user-friendly features and functionality. There is no doubt about it: just as banks did away with tellers for most transactions, so too most practices are slowly eliminating the paper anesthesia record. An anesthesia resident graduating now may never complete a paper record.

A review of the initial objectives of meaningful use yields a rather disappointing scorecard. It is not clear that the implementation of EMRs in anesthesia has had any meaningful impact on the quality of care provided, which has been impressive for years. Maybe some facilities have made improvements in the consistency of care. Probably, though, the real impact of EMRs in anesthesia will not be measured in improvements in the quality of care, but rather, in the establishment of quality benchmarks. How much can we reduce the cost without impacting the quality?

EMRs were supposed to reduce clinical paperwork. By this measure, EMRs have been a success, because they capture considerably more data than was ever captured in a paper environment. But meaningful use has also forced providers to worry about and document many more data elements than they ever had to before.

There is no question that EMRs provide greater access to details of a patient's medical history. This is clearly one of the biggest selling points. Details of previous surgeries, evaluations and test data are now readily available to anesthesia providers online. It is in the areas of record keeping and billing accuracy and efficiency that EMRs have failed to meet expectations. To calculate billing charges, anesthesia coders now routinely review 20-page pdfs rather than one-page paper anesthesia records. Integrating arcane billing rules into the EMR has been almost unresolvable. Additional days typically have to be added in the charge capture process to ensure that nothing gets missed.

All of which raises the question of whether EMRS have had any impact on healthcare costs. So far, there is little evidence that they have. In fact, the evidence suggests they have simply added a layer of expense to an already expensive system.

And so we are left wondering what has been accomplished. So many practices now have state-of-the-art record keeping but what has it gotten them? It is like having more than 100 cable channels but nothing worth watching. These systems are capturing a lot of data but there does not appear to be any more knowledge. All the expense and time that has been invested to get the specialty to this level of automation is probably just the end of the implementation phase. Now that the specialty has its new tools, it has to figure out how to use them effectively to achieve the original goals of the initiative.

There is a business saying that you cannot manage what you do not measure. However imperfect they may be, EMRs have provided much better and more complete management tools. They provide a mechanism to capture more data more efficiently than ever before. The questions now are what to do with this data, how to validate it and how to analyze and apply it. Much work remains to be done to make meaningful use truly meaningful. ▲

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PROFESSIONAL EVENTS

Date	Event	Location	Contact Info
January 9-12, 2017	J.P. Morgan 35th Annual Healthcare Conference 2017	Westin St. Francis Hotel San Francisco, CA	https://www.jpmorgan.com/country/US/en/jpmorgan
January 21-22, 2017	American College of Perioperative Medicine Interdisciplinary Conference on Orthopedic Value Based Care	Island Hotel Newport Beach Newport Beach, CA	https://opensource-med.org/
January 23-27, 2017	California Society of Anesthesiologists 2017 Winter Anesthesia Conference	Hyatt Regency Resort and Spa Maui, HI	https://www.csahq.org/continuing-medical-education/events/details/2017/01/23/cme-events/csa-2017-winter-anesthesia-conference
January 27-29, 2017	American Society of Anesthesiologists Practice Management 2017	Gaylord Texan Resort Grapevine, TX	http://asahq.org/practicemanagement
February 11-12, 2017	Arizona Society of Anesthesiologists 43rd Annual Scientific Meeting	Hilton Scottsdale Resort & Villas Scottsdale, AZ	http://www.az-anes.org/annualmeeting/2017/annualmeeting.html
February 19-23, 2017	Healthcare Information and Management Systems Society 2017 Conference and Exhibition	Orange County Convention Center Orlando, FL	http://www.himssconference.org/
February 24, 2017	McDermott Will & Emery's 2017 ASC & Physician Practice Management Symposium	Fontainebleau Miami Beach Miami Beach, FL	https://www.mwe.com/en/thought-leadership/events/2017/02/2017-asc
March 11, 2017	Michigan Society of Anesthesiologists 62nd Annual Scientific Session	Royal Park Hotel Rochester, MI	https://www.mmysahq.org/Events/AnnualScientificSession.aspx
March 25, 2017	Washington State Society of Anesthesiologists 2017 Spring Scientific Meeting	Bell Harbor International Conference Center Seattle, WA	http://www.wa-anesthesiology.org/index.php?option=com_mc&view=mc&mcid=72&eventId=519436&orgId=wassa
April 17-20, 2017	Becker's Hospital Review 8th Annual Meeting	Hyatt Regency Chicago, IL	http://www.beckershospitalreview.com/conference/

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