

A SELF-DIAGNOSTIC FOR HIGH-PERFORMING ANESTHESIA GROUP LEADERS

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Although the editor, bless her heart, steadfastly refused to let me have a sneak, pre-publication peek at the other articles that appear alongside this one, my educated guess is that each of them purports to give you *answers*.

I know that's why you usually read *Communiqué*. In fact, nearly every one of the hundreds of other articles that I've written falls into the "answer" category.

But what if the authors, me included, don't know you, don't know your group and don't know your particular circumstances? How immediately valuable, then, are those answers?

Often, questions—questions that you ask yourself, about yourself, about your anesthesia group, about your circumstances and about your business—are far more powerful than generalized



answers that are akin to "take two aspirins and call me in the morning" when your right femur is broken.

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STRENGTH MEANS SERVICE, NOT SCALE, IN TODAY'S ANESTHESIA MARKET

A recent analysis of the financial information of 104 leading health systems (more than 2,200 hospitals) found that size and profitability do not necessarily go hand in hand. The report, by Navigant, throws into question the common wisdom that scale is required to deliver the effectiveness, cost efficiency, care coordination, physician recruitment and retention, and risk management needed to succeed in today's environment.¹

Two-thirds of health systems experienced operating income decreases during the three-year period (2015-2017) following the expansion in insurance coverage that accompanied the Affordable Care Act. Overall, health system operating margins declined by 38.7 percent, with non-profit system margins decreasing by 34 percent and for-profit system margins dropping by 39 percent. More than one-fourth of the systems experienced operational losses in at least one of the three years, and 11 percent experienced negative margins throughout.

The findings "should compel health system management teams and boards to re-examine their assumptions about the future direction of their markets and organizations," the report concludes. The current economic expansion in the U.S. "will not continue indefinitely," and "when it is over, those who pay for care will place renewed pressure on the care system by pressuring rates and shifting more of the cost onto consumers, many of whom are unable to pay the patient share."

Health systems cannot count on their investment portfolios to offset declines in their operating income, but instead, must look closely at their markets, and size and target services to mirror actual demand, they conclude. They must also demand improvements in efficiency and effectiveness in their asset portfolios and in the value of their services, most notably for their patients.

Though the study does not explore the anesthesia market, one cannot help but ponder the potential parallels between recent findings regarding health system consolidation and the consolidation taking place within anesthesia.

ABC Vice President Jody Locke, MA, touches on that in this issue in "What Is the Future of Private Anesthesia Practice?" when he writes: "To the extent that larger entities can provide a better product cheaper, the consolidation will continue. The real question, though, is when is big too big? Is there a tipping point?" Mr. Locke contends that smaller, nimbler private practices attuned to their customers' (facilities') needs will remain poised to compete.

Achieving and maintaining that viability in a market as volatile as the current one demands attention to an unnerving array of strategic and business concerns. To help group practice leaders organize their thinking along these lines, Mark F. Weiss, JD, of the Mark F. Weiss Law Firm offers . . . questions. A lot of questions. And no answers. Only questions.

According to Mr. Weiss, "questions—questions that you ask yourself, about yourself, about your anesthesia group, about your circumstances and about your business—are far more powerful than generalized answers that are akin to 'take two aspirins and call me in the morning' when your right femur is broken." His list of questions is comprehensive, thought-provoking, and bound to trigger constructive action.

Also in this issue:

- One of Mr. Weiss's questions is "Do you have an overall business development strategy, or are you simply tactical?" Will B. Latham, MBA, of Latham Consulting, Inc., helps anesthesia groups keep the momentum going once they've held a planning retreat and developed that strategic plan.

Document planning efforts, develop detailed action plans for projects and initiatives, establish a process for monitoring progress on these projects and initiatives, empower your board to help move the group toward its goals, and revisit and revise the strategic plan, as needed, he recommends.

- Kelly D. Dennis, MBA, of Perfect Office Solutions, Inc., helps practitioners and coding professionals sift through the confusion of adding value for qualifying circumstances, notably, field avoidance and special positioning. Anesthesia providers need to know that qualifying services may be missed if they're not documented, and coding professionals need to know when and how to document them, and where the information can be found.
- Kathryn Hickner, Esq., of Kohrman, Jackson & Krantz, LLP discusses the basics of co-management arrangements, a structure being used to compensate anesthesia departments for their work on developing a perioperative surgical home (PSH).

As noted in our May 7, 2018 [eAlert](#) on this topic, our sense is that some anesthesiologists have reservations about embarking on a PSH at their institutions because of concerns about payment. Will that payment be fair and reasonable? According to Ms. Hickner, the co-management arrangement offers a viable option through which physicians may receive significant compensation from their involvement, but these agreements require careful structuring in accordance with state and federal healthcare regulations.

We look forward to seeing many of you at ANESTHESIOLOGY® 2018 in San Francisco.

With best wishes,

Tony Mira
President and CEO



¹ *Stiffening Headwinds Challenge Health Systems to Grow Smarter*, J. Goldsmith, R. Stacey, A. Hunter, Navigant, September 2018. https://www.navigant.com/insights/healthcare/2018/health-systems-financial-analysis?utm_source=pr&utm_campaign=hs-financial

ADDING VALUE FOR SPECIAL CIRCUMSTANCES: FIELD AVOIDANCE AND SPECIAL POSITIONING

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In coding and billing for anesthesia services, it often seems that just when you think you understand the rules, something changes.

One area of anesthesia billing that consistently confuses practices and coding professionals is the ability to add value for special circumstances. Qualifying circumstances, including field avoidance and special positioning, are unique to anesthesia services. To capture these services, your coding team must understand what the services are as well as how and when they may be reported.

Field avoidance and special positioning are not mentioned in the minimal section of Anesthesia Guidelines found in the Current Procedural Terminology® (CPT) code set, although they may be considered as services under the Special Report section. These circumstances are defined by the American Society of Anesthesiologists (ASA) as “Any procedure around the head, neck, or shoulder girdle, requiring field avoidance, or any procedure requiring a position other than supine or lithotomy, that has a minimum base value of 5, regardless of any lesser base value assigned to such procedure in the body of the Relative Value Guide®.”

Since the ASA definition includes a minimum base value of five units, this automatically *excludes* reporting with anesthesia services having a base value of five or more units. As there are approximately 85 anesthesia codes with a base value of five units or less, there is a good chance your anesthesia providers will qualify for additional payment for some of their anesthesia services, providing documentation supports the reported circumstance. Keep in mind that other



carriers may have definitions that vary. For example, Medi-Cal, the Medicaid carrier for California, may only allow these circumstances when the procedure has a base value of three units.

For special positioning, surgeries performed in either the supine or lithotomy positions are excluded. However, coders should be watchful for any other position documented and remember to check whether the anesthesia base value is less than five units.

Field avoidance indicates the anesthesia provider does not have access to the patient’s airway during surgery. This may be due to the nature of the case (e.g., face or shoulder surgery) or because the surgeon has the patient in a different position.

Both field avoidance and unusual positioning make the case a higher risk for the patient and more difficult for the anesthesia provider. Qualifying circumstances, which include both field avoidance and special positioning, are not

services covered by the Centers for Medicare and Medicaid Services (CMS) Medicare Administrative Contractors (MACs), although these exclusions are not mentioned in the Payment for Anesthesiology Services section of *Medicare Claims Processing Manual Chapter 12 - Physicians/Nonphysician Practitioners (Section 50)*.

As an added difficulty, there are no specific procedure codes or modifiers to describe field avoidance and special positioning. To find a relative example, one may use other anesthesia qualifying circumstances, such as CPT 99100 (Anesthesia for patient of extreme age, younger than one year and older than 70), to determine these services have a “B” or bundled status with anesthesia services. CGS Administrators, LLC includes anesthesia qualifying circumstances under Status B codes in the publication *Bundled, Inactive and Non-Payable Codes for 2015: Medicare Physician Fee Schedule Data Base* and indicates “Payment for these services is always included in payment for other services not specified. There are no RVUs [relative value units] or payment amounts for these codes, and separate payment is not made.”

However, it is important to understand that even though traditional Medicare does not cover qualifying circumstances, this is not always true for Medicaid programs, which vary by state. For example, Medi-Cal allows additional payment for anesthesia procedures complicated by unusual position or surgical field avoidance when identified with a 22 modifier to indicate the increased procedural services. Commercial insur-

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A SELF-DIAGNOSTIC FOR HIGH-PERFORMING ANESTHESIA GROUP LEADERS

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Below are some of the important questions that every high-performing anesthesia group leader should be asking themselves. These questions are designed to help you discover whether (you and) your practice's business engine could be running more efficiently, more effectively and more profitably *for you*.

Note that in recommending that you ask these questions, I'm not assuming that you or your business is damaged in any way or that you're not already successful. Rather, I know from decades of experience posing these questions that they drive insight, value and opportunity that can unlock even more results, more peace of mind and more profits for you.

Two points before we start: first, you'll notice that some of the questions seem to be similar, and you'll be right. They come at the same underlying point from slightly different angles to expand your mindset. And, second, you'll notice that the questions are not strictly organized by subject, and you'll be right, again. Some of the questions circle back to a topic to help you shake out your best thinking.

So, here goes:

1. What do you want from your practice's business?
2. What's your optimal ratio of owners to patient-facing non-owners?
3. What's your group's governance structure?
4. If the governance structure includes a Board of Directors or an equivalent:
 - a. How many members sit on the board?
 - b. Does the board involve itself in day-to-day operations or does it permit that responsibility to be exercised by the officers?
5. How much time and effort do you commit to management as opposed to practicing as an anesthesiologist?
6. In addition to time spent managing, how much time and effort do you commit to thinking, strate-

gizing and focusing on ways to improve your group's position, profits and strategic perspective?

7. At how many facilities does your group provide services?
8. At what types of facilities does your group provide services?
 - a. How many of each?
 - b. Have you considered the impact of the ratio?
9. What's your growth strategy (or are you content not to grow)?
10. Do you have a target list of facilities to approach?
11. What's your offer to those facilities?
 - a. How does your offer vary from that of your competitors?
 - b. Is that offer as irresistible as possible?
 - c. What guarantees do you make?
 - d. How do you approach the target facilities?
 - e. How many ways do you make contact with them?
12. Do you respond to requests for proposals (RFPs)?
 - a. Why?
 - b. Why not?
 - c. If so, what do you charge?
 - d. Do you know the average cost incurred to prepare a response?
 - e. What percentage do you "win"?
 - f. Has an RFP "win" ever generated a financial loss?



13. What's your competitive advantage?
 - a. How do you make it known?
14. What objections have been leveled at you by facilities that have rejected your overtures?
 - a. What strategies have you developed to defeat those objections?
15. How have you created an Experience Monopoly™, e.g., a monopoly in terms of the experience that the group provides to its "customers," i.e., hospitals, referring physicians and patients?
16. What annual or other periodic events, seminars and conferences does your group produce and implement each year to distinguish itself from others?
 - a. At each hospital?
 - b. In the community?
 - c. Have you protected the intellectual property generated by those efforts?
17. What's the group's relationship with each facility's CEO?
18. How long has each CEO been in office?
 - a. What's the per-facility turnover rate of CEOs over the past seven years?
19. What's the group's relationship with medical staff leaders?
20. How active are you and your colleagues in medical staff activities and leadership?
21. How often do you meet with each facility's CEO?
22. Do you have a written plan to further cement the group's relationship with each facility and each facility's CEO and other leadership?
23. What's your biggest opportunity for growth and increased profit?
 - a. If the answer is "no" and your group is not captive to an investment entity, is that a result of a conscious business decision by the group's leaders? What's behind that decision?
24. Do you have an ongoing process to expand your group's reach to other facilities?
25. Right now, today, how many potential new service sites are in your development queue?
26. How do you incentivize the development of new business?
27. Do you have a written succession plan for your group's leadership?
28. Do you have a written plan to deal with manpower in the event of a facility closure or a drastic reduction in the facility's scope of services?
29. What are your group's recruitment efforts?
 - a. Why would a recruit want to work for/with you?
30. What factors are considered in the hiring decision?
31. How competitive is your group's compensation structure?
32. What does the compensation plan incentivize?
 - a. Is it limited to maximizing production?
 - b. Do you use compensation to maximize conduct and behavior?
33. Does your group receive a stipend from a hospital?
 - a. Are you trying to increase it?
 - b. Are you trying to decrease it?
 - c. Do you have the right to renegotiate stipend support based on defined changes in circumstances?
34. Does your group offer a route to ownership (partnership, shareholder status, etc.)?
 - a. If the answer is "no" and your group is not captive to an investment entity, is that a result of a conscious business decision by the group's leaders? What's behind that decision?
35. What would your group do if a hospital it serves closes? If the hospital drastically cuts back its service lines?
36. Do you have the ability to cut staff in the event that demand for your services drops precipitously?
37. Do you have the ability to jettison facilities if their demand for your services drops precipitously?
38. Do you have the ability to cut services within a hospital if demand drops?
39. Do you have any system-wide exclusive contracts?
 - a. If not, have you sought them?
 - b. If so, do you have the right to jettison hospitals and other facilities in the system if demand for services or profitability drops?
40. If you're the leader of a site for a regional or national group, what plans do you have if the group pulls out or loses the exclusive contract?
 - a. What if the hospital refuses to renew with the regional/national group? What's your plan to re-start on a local basis?
41. How often do you analyze all of your payer agreements, both for reimbursement level and for competitiveness of terms?
42. How many physicians or nurse anesthetists has your group fired in the past five years?
 - a. If the answer is zero, is your group tremendously lucky, or does it put up with actions no normal person would?



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43. When did you last conduct a full-scale anti-kickback audit?
 - a. What tactics did you use in conducting it? Did you use an inside team or an outside team?
44. Do you have a written general compliance plan?
 - a. Is it implemented on an ongoing basis?
45. Do you have a written HIPAA privacy and security compliance plan?
 - a. Is it implemented on an ongoing basis?
46. Do you have a billing compliance plan?
 - a. Is it implemented on an ongoing basis?
47. Do you have general liability insurance in addition to professional liability insurance?
 - a. How recently did you shop the policy in terms of both coverage and price?
48. Do you have cyberliability insurance in addition to professional liability insurance?
 - a. Did you aggressively negotiate it using someone other than the broker who sold it to you?
 - b. How recently did you shop the policy in terms of both coverage and price?
49. Do you have a directors and officers and related business coverage policy?
 - a. Did you aggressively negotiate it using someone other than the broker who sold it to you?
 - b. How recently did you shop the policy in terms of both coverage and price?
50. In connection with your exclusive or even nonexclusive contracts with facilities, have you negotiated for protective covenants?
51. How many formal programs do you have in place to protect and expand the group's relationship with referral sources?
 - a. How often do you evaluate each program's effectiveness?
 - b. How many new programs have you tested over the past 24 months?
52. Do you know the marginal value of each referring physician/person/entity?
53. Do you have an answer to a hospital CEO who asks, "Why you? Why your group?"
 - a. If so, what's the answer?
54. Do you have an overall business development strategy or are you simply tactical?
55. What's your turnover rate with regard to owners/employed physicians/employed CRNAs or other mid-level practitioners/staff?
 - a. Do you know the cost of turnover?
56. Do you have a retention plan?
 - a. Is it implemented?
57. How are you spending your time?
 - a. Is that how it should be spent?
58. If you had one wish from a genie, how would you use it on your practice?
59. What's your long-term strategy for the business?
 - a. Do you see the business continuing forever?
 - b. Do you want to sell the business?
 - c. Do you see it running until a stopping point?
60. In regard to that same strategy:
 - a. What's your one-year goal?
 - b. What's your five-year goal?
 - c. What's your 10-year goal?
 - d. How much farther out do you project strategy?
61. Again, in regard to that same strategy, how are you going to achieve it?




62. Does your group operate any ancillary business lines?
- How many?
 - How many more have you considered?
63. Where do you see anesthesiology as a specialty in five years?
64. What's your biggest danger?
65. What's your biggest opportunity?
66. What's your greatest strength?
67. What's your attrition rate by job category?
68. Do you track referrals by source?
69. How do you (absolutely legally, of course) incentivize, promote and strengthen referral relationships?
70. What's the lifetime value of a referral relationship?
71. What's the lifetime value of a facility relationship?
72. How do you (in a legal manner, of course) incentivize, promote and strengthen facility relationships?
73. Do you have an active strategy and consistent tactics to market to new referral sources and facilities?
- How many concurrent strategies and tactics do you deploy?
74. Do you have a system in place to capture, on an ongoing basis, testimonials, endorsements and similar/dissimilar evidence of support?
- How do you use them?
 - Is it on an ongoing or sporadic basis?
75. Do you have a system in place to follow up with referral sources and facilities on a regular basis to cement relationships, expand opportunities and avoid missteps?
76. When was the last time that you engaged a "red team" to test the disruption of your business?
77. If you use covenants not to compete, should you?
- If you *don't* use covenants not to compete, should you?
 - If covenants not to compete aren't enforceable in your locale, how many alternatives do you have in place?
 - Why?
 - Why not?
78. Do you know the lifetime value of a patient relationship?
79. Do you know the *postsurgical value* of your patient relationships?
- Do you understand the implications of the question?
80. What marketing efforts do you deploy beyond the walls of the hospital?
81. Do you know the return on investment of each of your marketing/business development efforts?
82. How do you maintain a relationship (note: sending bills is not maintaining a relationship) with patients postsurgery?
- Do you have an active email list?
 - How do you utilize it?
 - How often?
83. Do you have a website?
84. Does your website provide value to patients, referral sources, facilities and prospects?
- How?
 - If not, why not?
85. What actions have you taken to protect your group's intellectual property?
86. What actions have you taken to develop your group's intellectual property?
87. What actions have you taken to license or otherwise exploit your group's intellectual property?
88. What kind of competitor research do you perform?
89. What do your competitors offer that you don't?
- Why do they offer it?
 - Why don't you?
90. Does your group provide compensation for leadership work?
- If not, why not?
 - If so, is the amount sufficient in light of the size and profitability of the business?

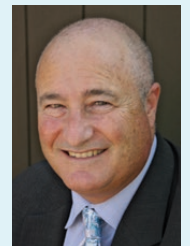
Congratulations!

If you asked yourself, *and then earnestly considered*, even 80 percent of the questions, you're probably ahead of 93 percent of your colleagues in anesthesia group leadership positions.

And instead of just reading someone's answers to generalized problems, you've written answers to issues completely on target with your group's issues, interests and concerns. Or, at the very least, you've been spurred on to ask yourself and your colleagues essential questions that go to the heart of your group's business.

Now, go do something about it. 

Mark F. Weiss, JD, is an attorney who specializes in the business and legal issues affecting physicians and physician groups on a national basis. He served as a clinical assistant professor of anesthesiology at USC Keck School of Medicine and practices with The Mark F. Weiss Law Firm, a firm with offices in Dallas, Texas and Los Angeles and Santa Barbara, California, representing clients across the country. He can be reached by email at markweiss@advisorylawgroup.com.





ADDING VALUE FOR SPECIAL CIRCUMSTANCES: FIELD AVOIDANCE AND SPECIAL POSITIONING

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ance policies often recognize the value of these services, although the reporting processes may differ.

Last revised in 2011, the policy of Blue Cross Blue Shield of Hawaii requires the use of a 23 modifier (unusual anesthesia) and specifies it “should be used to indicate anesthesia services complicated by procedures performed in the prone position or by field avoidance.” The policy also specifies which CPT codes may be reported and differs from the ASA recommendations, allowing a unit value of one.

If carrier policy does not define whether qualifying circumstances are covered, they should be billed and reported. No policy will cover unbilled or unre-

ported services! Unless otherwise specified, coders may report either of these circumstances with a 22 modifier and “field avoidance” or “xxx position” in box 19 or the electronic equivalent.


It is helpful for anesthesia providers to understand that qualifying services may be missed if they are not clearly documented, and it is helpful for coders to understand when these services might be performed and how they are documented. Coders cannot capture billable services that are not indicated on the anesthesia record, even if they are marked on an internal billing sheet, as billing sheets are not usually considered part of the patient’s medical record.

As there is no universal anesthesia record and a typical anesthesia billing company sees many different records, coders must determine where on each record the anesthesia providers document these types of services. This can be challenging with paper records and handwritten notes. It is also difficult if the anesthesia providers use stick figures to draw the patient’s position. Sometimes the coders can’t tell whether the feet are supine or prone.

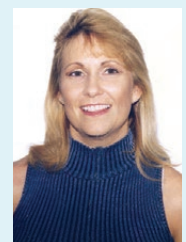
With a paper record, the clearest way to document is with a legible note in the remarks or comments section. Electronic anesthesia records (EARs) are much easier to read and may have a field summary that includes an area in which to document qualifying circumstances. If

the EAR doesn’t have a field summary, coders should look within the body or comments section. It is important for coding professionals to know where qualifying circumstances information is documented in your practice.

Specific anesthesia policy and anesthesia billing rules are often difficult to find. If a policy is found that doesn’t address qualifying circumstances, it should be reported. If no policy is found, it should be reported. If claims are denied, the insurance company should be contacted to determine the reason. If an appeal is necessary, the best way to help an insurance company understand the value of the service is for the coding team to be prepared to explain why the services have a higher value and to include information provided by the ASA or other reputable resources.

Regardless of the depth and length of their experience, your coding staff will continue to encounter challenges such as these. The best way to support them is to encourage them to ask questions and scour all available resources for answers. 

Kelly D. Dennis, MBA, ACS-AN, CANPC, CHCA, CPC, CPC-I, has 35 years of experience in anesthesia and speaks about anesthesia issues nationally. She has a Master’s Degree



in Business Administration, is certified through the American Academy of Professional Coders, is an Advanced Coding Specialist for the Board of Medical Specialty Coding and serves as lead advisor for their anesthesia board. She is also a certified healthcare auditor and has owned her own consulting company, Perfect Office Solutions, Inc., since 2001. She can be reached at kellydennis@attglobal.net.

Resources

CGS Administrators, LLC (most current), 2015 Bundled, Inactive, and Non-Payable Codes for 2015

https://cgsmedicare.com/pdf/j15_fee_schedules_2015.pdf

HMSA Provider Resource Center, Anesthesia with Prone Position or Field Avoidance

https://hmsa.com/portal/PROVIDER/zav_pel.ph.ANE.900.htm

Medi-Cal

http://www.partnershiphp.org/Providers/Policies/Documents/Claims/Medi-Cal_Section%203.Subsection%20X.A.pdf

https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/anestcms_m00.doc

Medicare Claims Processing Manual Chapter 12 - Physicians/Nonphysician Practitioners

<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf>

HOSPITAL CO-MANAGEMENT ARRANGEMENTS: BASICS FOR ANESTHESIOLOGISTS

Kathryn Hickner, Esq.

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Anesthesia groups continue to be presented with opportunities to participate in hospital co-management arrangements. These arrangements are one way that hospitals and physicians can align in order to improve the quality and efficiency of care provided through one or more hospital service lines.

By achieving such objectives, participating hospitals and physicians are likely to receive more favorable third-party payer reimbursement and to become more competitive.

Before diving into these relationships, however, anesthesiologists should be aware of a few basic facts:

- **Each hospital co-management arrangement is unique, but they usually share certain commonalities.** Hospital co-management arrangements generally involve a hospital partnering with physicians to improve the performance of one or more hospital service lines. Such partnerships are often structured as a joint venture through either the establishment of a separate legal entity or direct contracts with certain physicians.

The arrangements allow physicians to take an active role in addressing the operational challenges that serve as roadblocks to improving the quality and efficiency of services provided. The arrangements focus not only on specific tasks to address operational issues, but also include financial incentives for achieving specific performance-based objectives with respect to the relevant service lines. The emphasis



is on achieving real and measurable progress, which is then rewarded, directly or indirectly, in the form of increased reimbursement from third-party payers.

- **The underlying goals of hospital co-management arrangements are aligned with those of other quality initiatives.** More specifically of interest to anesthesia providers, the underlying objectives of a hospital co-management arrangement are the same as the underlying objectives of the interdisciplinary peri-operative surgical home (PSH) championed by the ASA. These objectives—better health, better healthcare and reduced healthcare expenditures—are, in turn, the same goals of the triple aim for healthcare put forth by the Institute for Healthcare Improvement.

Accordingly, hospital co-management arrangements are sometimes adopted by hospitals as a tool for achieving and advancing the PSH. The two concepts go hand in hand. That being said, numerous other types of popular alignment structures can be used to achieve similar objectives, such as clinically integrated networks and accountable care organizations.

- **Hospital co-management arrangements have the potential to significantly benefit hospitals, physicians and patients—and that's exciting.** When successful, co-management arrangements facilitate cooperation among hospitals and physicians to improve the services provided to patients. As a result, the hospitals and the physicians are better positioned for success under

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HOSPITAL CO-MANAGEMENT ARRANGEMENTS: BASICS FOR ANESTHESIOLOGISTS

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the evolving healthcare payment regime, which focuses on paying for the value of services provided instead of volume alone.

Co-management arrangements also can help to build trust between the hospital and its medical staff, improve morale and facilitate teamwork. This is especially true with respect to those hospitals that are faced with a toxic hospital versus physician dynamic.

Through hospital co-management arrangements, physicians and administrators are required to sit down at a table and work together to achieve common and mutually beneficial goals. When there is a sincere commitment and good faith buy-in from all involved, co-management arrangements sometimes open and change the historical dialogue between physicians and hospitals. When co-management arrangements are successful, the improved coordination and collaboration results in better care and better outcomes.

- **Hospital co-management arrangements vary in scope and complexity.** Some hospital co-management arrangements focus on a single service line (e.g., anesthesia alone) but many focus on more than one service line (e.g., anesthesia and all surgical services at a hospital).

Some hospitals have adopted single service line co-management arrangements as an initial step of a multi-phased approach to eventually adopt co-management arrangements that cover multiple service lines, an entire hospital or

even to serve as the basis for a clinically integrated network. As the scope of the arrangement expands, so does the required collaboration among the hospital and its physicians, the potential positive impact of the arrangement and the potential compensation available to participating physicians.

- **Those entering co-management arrangements should be aware of applicable healthcare regulatory constraints.** Hospital co-management arrangements need to be carefully structured in accordance with state and federal healthcare regulations.

More specifically, similar to other relationships between hospitals and their physicians, hospital co-management arrangements need to be reviewed under the Federal Anti-Kickback Law, Stark Law, Civil Monetary Penalty Laws, tax exempt laws and parallel state laws. Although a discussion of these laws is beyond the scope of

this article, note that the analysis of any co-management arrangement under these requirements is nuanced and governed by numerous statutes, regulations and pieces of governmental guidance. Anesthesia groups should consult with their attorneys to understand the legal risks related to any proposed co-management arrangement.

- **Physicians may receive significant compensation from their involvement with successful hospital co-management arrangements.** Payments to physicians under a hospital co-management arrangement often include two types of fees: base fees and incentive fees. Permissible payment structures may take the form of hourly compensation for attending committee meetings, developing policies and procedures, or providing other management or administrative services. They may also include incentive bonus compensation or profit distributions that result from achieving certain pre-defined and objective quality,





satisfaction and efficiency benchmarks. For those co-management arrangements that include joint venture entities and require physicians to make a capital contribution, the physicians may be required to assume a degree of financial risk. Such physicians may enjoy the upside (but also the downside) of such investment through their capital contributions and profit distributions (if any).

- **The financial relationships between hospitals and physicians in co-management arrangements need to be carefully structured.** The compensation paid to physicians under any co-management arrangement must be within the range of fair market value, may not be influenced by the value or volume of referrals that they provide to the hospital or their political influence in the organization, and must be commercially reasonable. Performance standards should be based upon objective and evidence-based measures that are appropriate for the hospital.


Any hospital that is a party to such an arrangement should engage an independent, qualified and experienced healthcare valuation consultant to provide guidance and an opinion, in close consultation with the hospital's attorneys, regarding each of these requirements.

Physicians who participate in co-management arrangements should ask questions about such valuation and the care that has been taken by the hospital to ensure that such financial relationships would withstand governmental scrutiny under state and federal healthcare regulations.

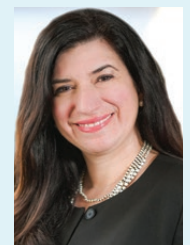
- **No physician should enter a hospital co-management arrangement until the physician has had such arrangement reviewed on their behalf from a legal perspective.** It would be inadvisable for physicians to blindly trust the hospital attorneys to ensure that the arrangement is compliant. Most healthcare attorneys are able to share horror stories of problems that have arisen when a physician

relied on the hospital attorney and the hospital attorney made a mistake.

Physicians who become involved in a co-management arrangement by taking an equity interest in a joint venture entity that will manage one or more service lines, or by entering an administrative services agreement, need to work with their own attorney to review the arrangement and ensure that they are legally protected from a corporate, contract and health law perspective. The attorney needs to review the arrangement from a regulatory perspective under the laws mentioned above.

Further, an attorney should review the governing documents and provide guidance to the physician about any usual provisions that the physician may not expect, such as non-competes or other restrictions that may survive after a physician leaves such arrangement. The physician attorney should also consider the interaction between the co-management arrangement agreements and other direct or indirect agreements between the physician and the hospital. 

Kathryn Hickner, Esq., is a partner at Kohrman, Jackson & Krantz LLP in Cleveland. Ms. Hickner's experience extends into nearly all areas of healthcare law, but she specializes in transactional matters and compliance with federal and state healthcare regulations, including federal Stark and state self-referral laws, federal and state anti-kickback laws, HIPAA and state privacy laws, and federal tax exempt laws. She can be reached at keh@jkj.com.



SETTING YOUR STRATEGIC GOALS IN MOTION: A HOW-TO GUIDE FOR ANESTHESIA GROUPS

Will Latham, MBA

President, Latham Consulting Group, Inc., Chattanooga, TN

I find the great thing in this world is not so much where we stand, as in what direction we are moving; to reach the port of heaven, we must sail sometimes with the wind and sometimes against it—but we must sail, and not drift, nor lie at anchor.

— Oliver Wendell Holmes

In earlier *Communiqué* articles (“[Hope is Not a Strategy: A Primer for Anesthesia Groups on Strategic Planning](#),” fall 2016 and “[Hope Is Not a Strategy: How to Create Your Strategic Business Plan](#),” winter 2017) we discussed the reasons for developing a strategic plan and how to create one. But if you develop the plan and declare victory, you only get half of the benefit from the process.

Top-performing anesthesia groups take several steps *after* holding their planning retreats to develop a strategic plan. We encourage your group to consider doing the same.

1. DOCUMENT YOUR PLANNING EFFORTS

The work done and decisions made at the retreat should be documented in a written report. It doesn’t have to be fancy; just document the decisions made at the retreat.

It is important to do so for the following reasons:

- **Confirm agreements:** The report should be sent to all participants, and they should be asked to confirm that it represents the decisions made at the retreat.
- **Communicate to those who did not attend:** Several members of the



group may have been unable to attend the retreat. The report can help communicate to them what happened at the retreat and the decisions the group reached.

- **Monitor activities:** As will be discussed below, the report should be used as a tool to help monitor the group’s progress.

2. DEVELOP DETAILED ACTION PLANS

Another important step after the retreat is to develop detailed action plans. During the retreat, the attendees should have identified projects or initiatives, assigned responsibility for implementing the projects and initiatives, and set general dates for completion (or dates for status reports).

However, those responsible for these various projects should develop detailed action plans that specify:

- What will be done? What steps will be taken?
- Who will do it?
- What will the costs be?
- What will the benefits be?
- When will it be completed?

Here are some guidelines to consider when creating action plans.

- Establish the specific goal of the plan. Why is it being done?
- Identify who has overall responsibility for the plan.
- List the steps to be performed to complete the plan.
- Indicate the date each step should be completed.
- Develop and include all added manpower and expenses the plan will require.

- Develop and include quantitative and qualitative results expected from the plan.

3. SET UP A MONITORING PROCESS

To derive the most value from a planning process, ongoing monitoring is needed to assess how well the group is meeting the goals of the plan. There are two reasons to do so:

- a. Monitoring performance can help keep the group on track.
- b. Some physicians complain “we met and decided, but then didn’t do anything.” Monitoring helps connect the work done at the retreat to the various initiatives’ implementation.

It’s best to assign an overall coordinator for this monitoring effort. We believe assigning it to a physician is best, but it could fall to the manager. It is often best if the group president performs this function.

Periodically, the coordinator should collect updates on the various initiatives. On a regular basis—perhaps quarterly—the group should review the plan to see how well it is performing. Some groups hold an evening dinner meeting to review the update.

4. EMPOWER YOUR BOARD

Plans come to nothing if they are not implemented. One of the key responsibilities of any group’s governance team is to move the group toward achieving its strategic goals. Medical groups move forward by discussing issues, making decisions and setting policy.

If your group has established a board or executive committee, typically that governance body makes decisions or sets policy within its level of authority. “Authority” involves what the board can



do without having to go to a higher authority, such as the shareholders.

Authority typically involves:

- Who can you hire or fire?
- How much money can be spent?
- What contracts can you enter into?
- What strategic issues can you decide?
- How far can the board go in dealing with disruptive issues?

Medical group governing boards often get mired down while addressing important group issues or trying to make decisions. They also have a tendency to micromanage rather than govern.

Here are some ways to overcome these challenges.

Send it to Committee

We have found that the best medical group boards use their committees to process information prior to the board addressing an item. When an item is raised at the board level, the first step is often to send it to a committee to:

- Define the scope of the issue
- Gather needed data

- Analyze the data
- Recommend a solution

Once the committee has developed a solution or recommendation, this information should be presented to the board. However, the board must be extremely careful not to redo the work of the committee. If the board feels the committee has not completed the assignment, it should be sent back to the committee for further work.

In addition, the board should make every effort to accept the committee’s recommendation. Why? If the board always rejects the committees’ recommendations or re-does the work, the committees will reach the conclusion that their thoughts are not being considered and stop doing the work.

Avoid Micromanagement by Setting Policy

As a board tries to do its work, it’s often tempted to move from governance/oversight to organization micromanagement. The best way to avoid this problem is to focus the board on setting policy rather than on making decisions.

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A policy is a statement that guides and constrains the subsequent decision making. The goal of setting policy is to try to specify the ends rather than the means.

In setting policy, the board should identify what is to be accomplished, and a range of acceptable and unacceptable means for achieving the objectives. This could include a set of directives for how the group will operate in the future, or instructions to management on implementation.

To help the board avoid micro-management, it's often helpful to remind them that they don't have to (and shouldn't) make every decision. The board has options, which include:

- Requesting proposals and recommendations from management prior to making a decision. Example: we need to avoid problem X. Management: develop a set of alternative methods to achieve this end.

- Delegating decision-making authority with constraints. Example: we need to avoid problem X. Management: develop a set of alternative methods to achieve this end that costs less than \$50,000.
- Delegating decisions with exceptions. Example: we need to avoid problem X. Management: develop a set of alternative methods to achieve this end, but it must be a process solution rather than a technology solution.
- Retaining authority and making decisions itself.

The best boards spend most of their time setting policy and always ask, "Is this something that management should decide once we've provided guidelines?"

5. REVISIT THE PLAN


The world is not a static place. Your strategic plan should not be static either. The most effective groups update their strategic plans on a regular basis, either yearly or every other year.

Naturally, a significant internal or external change should trigger a review and re-discussion of the group's plans. For example, if the group loses a significant contract or portion of business, it may need to meet and develop plans to regain its footing.

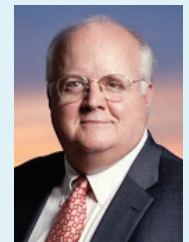
Groups should consider these areas periodically.

- The group's recruitment plans should be updated at least annually. Someone once said that "Recruitment is like roller skating. Sometimes you go where you want to go and sometimes you go where the damn things take you." People

may leave, retirements may take place and new service demands may arise.

- The group's compensation plan (or time/money balance) should be looked at approximately every other year. Some groups discuss their compensation (or time/money/vacation) at every meeting, thereby reducing the time to discuss important strategic issues. Many groups agree that they will only discuss changing the current system once a year or once every other year unless 40 percent of group members sign a document requesting a review. 

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



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



WHAT IS THE FUTURE OF PRIVATE ANESTHESIA PRACTICE?

Jody Locke, MA

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Many anesthesia providers look at the changes taking place in the specialty and shake their heads. Today's practices bear little or no resemblance to practices of 10 or 20 years ago. Who could have envisioned groups with hundreds or even thousands of providers working for one entity?

That unforeseeable future is today's reality. And what do we make of all the mergers and acquisitions? Where did all this venture capital money come from and why is there such interest in buying anesthesia practices? Is this a preview of coming attractions? Are we witnessing the end of an era and the disappearance of the single hospital private anesthesia practice? And if we are, how should providers prepare for the practice of the future?

As we noted in an article on the largest anesthesia entities ([“Strategy and Adaptability in a Competitive Market: Lessons from the Nation's Largest Anesthesia Organizations.”](#) *Communiqué*, summer 2017), as of April 1, 2017, eight organizations employed approximately 22 percent of all anesthesia providers.

The voracious expansion continues. A practice of 100 providers was once a rarity. Now, there is one in almost every state. The original anesthesia mega-group, Anesthesia Services Medical Group (ASMG) in San Diego, with 190 providers, is not even in the top 10 today. Most of the 25 largest practices profiled at the 1994 ASA practice management conference have either grown significantly or merged with other practices.

I was the administrator for North Shore Anesthesia Associates (NSAA) in



Manhasset, New York, when it was a large practice of about 50 providers (anesthesiologists and CRNAs) serving Manhasset's North Shore University Hospital. After I left, the hospital merged with Long Island Jewish Hospital, and NSAA became North American Partners in Anesthesia (NAPA), which now provides care from Poughkeepsie to Baltimore, up and down the East Coast, and as far west as Chicago. NAPA now employs more than 1,700 providers.

MERGER DRIVERS

Across the country, we are witnessing an unprecedented level of merger activity, and there is no end in sight. Pick a state and you will see examples. One of the initial, and most notable, was the merger of anesthesia practices serving the Methodist Hospitals in Houston. Inspired by the vision and leadership of past ASA

President John M. Zerwas, MD, Greater Houston Anesthesiology (GHA) set a new standard for mega-group management and influence in a local market.

The anesthesia practice at Good Samaritan Hospital in Los Gatos, California, joined an entity called CEP America Anesthesia with the intention of creating a regional practice network. The new entity, Vituity, has a substantial foot print in the Bay Area. A number of practices in the Chicago area have come together to form Midwest Anesthesia Partners (MAP). They are coming to represent all the large anesthesia practices in suburban Chicago.

Many financial and strategic factors contributed to the aggregation. There is a widely held perception that the single-facility anesthesia practice is quickly becoming an anachronism and that you cannot survive as a little fish in a big pond.

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Some predict that all anesthesia providers will inevitably work for some much larger entity in which they will be little more than salaried employees. Many believe that we will eventually see the end of the private anesthesia practice as anesthesiologists and CRNAs continue to become hospital employees. But will the trend continue?

Some significant trends led practice managers to the conclusion that big is better. Put another way, if you don't have leverage, you don't have power. The specialty that had historically been captive to other hospital players for its income and lifestyle started to realize that occupying the bottom layer of the medical food chain was not very secure. To paraphrase Dr. Zerwas, it was time for anesthesiologists to regain control of their own destiny.

The history of anesthesia aggregation is the history of two distinct trends that eventually merged into one powerful phenomenon: 1) similar practices in given markets exploring ways of consolidating those markets; and 2) other practices looking at the national market from a more global perspective. We can think of them as the localists and the globalists.

In the early 1990s, mergers were being consummated in Dallas, San Antonio, Houston and various other cities. The



mergers focused on three issues: managed care contracting, provider productivity and market security. These were physician-owned entities striving to provide a better income and lifestyle to their physician owners.

STORIES OF CONSOLIDATION

At about the same time, a new form of anesthesia entity started making its presence known: anesthesia staffing companies, commercial ventures structured to respond to hospital requests for proposals (RFPs), a term that would come to strike fear in the hearts of established anesthesia practices. These were business entities whose business plan was to grow by obtaining anesthesia contracts wherever they became available. The anesthesia landscape started to change as hospital administrators who had become dissatisfied with their anesthesia providers explored the market with RFPs.

Premier Anesthesia was one of the first to gain national attention, but it was not the only one. Some were successful, and others not. One of the most successful started as an anesthesia practice at Memorial Regional Hospital in Holly-

wood, Florida, one of the largest hospitals in south Florida. Sheridan Anesthesia took its name from the street on which its corporate offices were first located. It soon established itself as a major player in the Florida market and then expanded into a significant provider of anesthesia services across the country.

Some anesthesia practices grew because their hospitals merged. We sometimes refer to these as shotgun marriages. When Mount Carmel Hospital in Columbus, Ohio, purchased a suburban hospital that would become known as Mount Carmel East Hospital, the administration insisted just one anesthesia practice cover both facilities.

Many others came into being as a matter of strategic opportunity, including many in Texas. Three major markets saw the growth of large entities at about the same time: STAR Anesthesia and Tejas Anesthesia in San Antonio, GHA in Houston and Pinnacle Anesthesia in Dallas. As the various anesthesia practices that would come together to form GHA worked through the legal and logistical challenges of merging practices with different structures and cultures, the partici-



pants joked about what the new entity would be called. Some humorously suggested they call it DBAG for Damn Big Anesthesia Group.

From an anti-trust perspective, it was probably good that they did not go with that name. It did not take long for GHA to leverage its role within the Methodist Hospital System to become a major force in the Houston market.

By the end of the 1990s, merger mania was sweeping the country. The megagroups were focused on growth. Small practices were looking for appropriate partners. And while RFPs were the bane of existence for many struggling anesthesia practices at hospitals with poor payer mixes and inconsistent volumes, many of the largest organizations saw them as the key to growth and success.

This was a new era in anesthesia. Prior to 1994, when the ASA held its first practice management conference in Phoenix, most practices had never focused on practice management. Once Pandora's box was knocked open, there was no stopping the discussion. ASMG of San Diego led the charge, holding sessions across the country promoting a new

model of anesthesia practice based on its accomplishments. In one year, they met with 40 anesthesia practices. They also spun off a separate management company called Integrated Specialists Management Services (ISMS).

GAINING LEVERAGE

Three themes inspired much of the discussion. First, many of the participants in this race to grow saw the creation of large practices as the only way to gain financial leverage in an increasingly challenging managed care market.

Second were those who saw contracting as just one piece of a larger puzzle, with obtaining and maintaining profitable hospital contracts as the key to security in a competitive market.

Third, as articulated by Dr. Zerwas, a GHA founder, was the notion that the key to group strategy was to control the group's destiny as anesthesia providers.

Most anesthesia providers were essentially captive to their hospital and surgical community for their income and lifestyle. The opportunity, according to Dr. Zerwas, lay in creating service organizations that partnered with their administrations.

Eventually, these three trends came together. Entities that had successfully consolidated a given geography started to explore the potential for expansion. All of the large national groups started as hospital anesthesia practices. Growth begat corporate restructuring and governance and management consolidation. Eventually, they developed sales and marketing arms. Before long, the only limiting factor was financial, and this void would soon be filled with huge infusions of venture capital.

Most anesthesia groups look at their businesses in terms of a hierarchy of financial opportunity: better payer contracts, better hospital contracts and the increased use of CRNAs. With regard to managed care contracts, some entities were more successful than others, although some of the successes were impressive. The real focus of most of the entities was the contracts with facilities. Little by little, subsidies were becoming almost more important than fee for service collections and a major focus of the management of these big groups. Depending on the market and its use of CRNAs, changes in staffing model were viewed as another opportunity to enhance profitability of practices.

ARE THERE LIMITS?

Few empires last forever. Most Americans are aware of the fate of the British Empire on which the sun never set. So what are the growth limits of anesthesia practices? Are they geographical? Are they financial? What is the counterbalance to practice expansion? Is it competition? When does an entity reach its peak and start to recede?

In the 1990s, the physicians at Presbyterian Hospital in Albuquerque created a practice, Anesthesia Associates of New Mexico, that spanned 90 miles from Albuquerque to Santa Fe. The arguments for





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merging seemed compelling. The problem was that the Santa Fe doctors started to feel that this new arrangement was taxation without representation. They were sending money to the mothership, but did not feel there was a commensurate reward.

The subgroup decided that swift and nimble was a better strategy and broke off. They were not alone. A review of the nation's largest anesthesia entities today highlights the essential qualities of a successful organization. First, members must have common financial goals. The practice structure must work for the majority of providers. In other words, there must be a global sense of constituency and tangible benefits for the providers.

What is virtually every anesthesia provider's goal? It is the freedom to provide quality anesthesia care with a minimum of interference. At a retreat that defined the culture of the San Diego group, members agreed that the group was preeminent in matters of contracting and benefits while the individual was preeminent in all clinical matters. The idea was to give each provider the opportunity to work as hard or as little as they wanted.

Since San Diego is basically a lifestyle city, the practice became a lifestyle practice.

Today, two types of large anesthesia entities predominate: those that still function as anesthesia group practices and those that operate more as staffing companies. The first focuses on physician management and control. OAG, ASMG and United Anesthesia Services, PC are examples.

The second type of entity has a financial focus, such as Envision, NAPA, TeamHealth or Somnia. Physicians work for these entities because they know how hard they have to work and how much they will get paid. Employment is more like traditional employment with a private company. The difference is that, usually, a smaller pool of managers shares in the profits.

Most anesthesia providers will say that their goal is to be compensated fairly for their work and to have enough room in their schedule for a home and personal life. Some practices have been more successful at this than others. One factor that can become a challenge to large practices is demographics. Many practices have been undone by younger providers with more aggressive strategic plans.

STRUCTURES AND EXPECTATIONS

Identifying the best structure for an anesthesia entity is no small challenge. Historically, most anesthesia practices were loose confederations of independent providers committed to protecting a franchise and maintaining the status quo. At first, the notion of ceding control to a limited number of board members for hiring and firing and other business matters represented a huge cultural challenge. However, once the precedent was established, most groups realized that this governance was essential. As groups grew, it became obvious they could not manage a 40- or 50-provider practice the way they managed a group of 10 or 15.

Anesthesia providers are, by definition, independent. Former ASA President Peter L. McDermott, MD, once quipped that managing an anesthesia practice is "like herding cats." Anesthesia providers want someone else to handle business matters, but to play a role in major decisions. Therefore, maintaining a sense of constituency in a large entity can be a challenge.

There is almost no large anesthesia entity today that does not have at least one subgroup that believes it would be better off breaking away and managing its own practice, like the Santa Fe group. Some entities are more successful at managing the dissidents than others.

What do the members of these groups hope to gain as a result of their employment? Usually, it is income and lifestyle, qualities that each anesthesiologist defines differently. When a physician or CRNA joins a large group, they have certain expectations. Their satisfaction will depend on how well the group meets their income and lifestyle expectations. If the provider starts to feel that they were sold a bill of goods, they will eventually look elsewhere.





One thing we can say about today's anesthesia providers is that they are more mobile than ever. In the current environment, providers vote with their feet. High turnover can undermine a large staffing company's credibility with its client hospitals. In the fanciful memories of many older providers, things were simpler. You worked hard in high school to get into a good college and be accepted by a reputable medical school. Competition was stiff for the best residency slots. It took years of struggle to get a good hospital position, but once you were there, you were there until you retired.

Today, this career path is the exception rather than the norm. We've seen the advent of the "starter practice," and job security often seems out of reach. We often tell residents that the challenge is to pick the horse that will go the course. The reality is that you may ride many horses before you reach the end of your career.

A BALANCING ACT

Ultimately, the business of anesthesia is about having more, and more profitable, contracts. In today's competitive market, groups grow and shrink based on their skill in this area. Many hospitals change anesthesia service providers every few years. Getting a contract can be quite different from making a contract work.

Getting a contract is simply a matter of defining a set of terms, the most important of which are financial, to which the hospital agrees.

There is a saying, though, that when it comes to hospital contracting, anyone can get the number right today, but will it be right tomorrow? A hospital contract is a balancing act that involves gaining access to enough revenue to hire enough qualified providers. Three factors undo many contracts and cause private groups to fail: poor management, eroding payer mix and scope creep. In many cases, a combination of all three causes the hospital to pull the plug.

Hospitals expect someone to be in control so that what is agreed to can be consistently delivered. Many practices do themselves in because they do not interact with the administration as a team. Increases in Medicare and Medicaid populations will undermine financial viability for groups that do not negotiate flexible arrangements that anticipate reasonable changes in volume and payer mix.


The biggest challenge facing groups today is scope creep, in which, little by little, the administration asks for more service without providing additional compensation. It is a universal problem that few organizations have figured out how to address effectively. And so it is

that gaining a new contract can be a mixed blessing: an opportunity to enhance and secure the practice or a huge mistake.

SERVICE IS KING

Just as we have seen consolidation in other industries, so, too, should we expect it in healthcare. To the extent that larger entities can provide a better product cheaper, the consolidation will continue. The real question, though, is when is big too big? Is there a tipping point? Very few practices seem to have found it. Most of the largest entities get to a point where they trade contracts back and forth with the other large entities.

So what is the anesthesia trump card? It is the quintessential service specialty. Smaller private practices that are willing and able to provide a better service, custom-tailored to the customer's specific needs, will always have the edge over large national entities that are bureaucratic and formula-driven.

Every practice that is considering selling out to a larger entity should ponder one question: what is its value proposition? Would the members rather be masters of their own destiny or someone else's? There will always be a place for the small, innovative practice that understands the importance of good customer service. 

Jody Locke, MA, serves as Vice President of Anesthesia and Pain Practice Management Services for Anesthesia Business Consultants. Mr. Locke is responsible for the scope and focus of services provided to ABC's largest clients. He is also responsible for oversight and management of the company's pain management billing team. He is a key executive contact for groups that enter into contracts with ABC. Mr. Locke can be reached at Jody.Locke@AnesthesiaLLC.com.





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PROFESSIONAL EVENTS

Date	Event	Location	Contact Info
September 30-October 3, 2018	Medical Group Management Association 2018 Annual Conference	Boston Convention & Exhibition Center Boston, MA	https://www.mgma.com/events/mgma18-the-annual-conference
October 8-13, 2018	American Association of Oral and Maxillofacial Surgeons 100th Annual Meeting, Scientific Sessions and Exhibition	McCormick Place West Chicago, IL	https://www.aaoms.org/meetings-exhibitions/annual-meeting/100th-annual-meeting
October 12, 2018	American Society of Anesthesiologists International Forum on Perioperative Safety & Quality	Hilton San Francisco Union Square San Francisco, CA	https://www.asahq.org/ifpsq/asa
October 13-17, 2018	American Society of Anesthesiologists ANESTHESIOLOGY® 2018 Annual Meeting	Hilton San Francisco Union Square San Francisco, CA	https://www.asahq.org/annualmeeting/?utm_source=asahq&utm_medium=landing-page&utm_campaign=Annual-Meeting
October 18-20, 2018	Becker's ASC Review 25th Annual Meeting: The Business and Operations of ASCs	Swissôtel Chicago, IL	http://www.beckersasc.com/annual-ambulatory-surgery-centers-conference/
October 28-November 2, 2018	California Society of Anesthesiologists 2018 Fall Anesthesia Conference	Fairmont Orchid Kamuela, HI	http://www.csahq.org/continuing-medical-education/events/details/2018/10/28/cme-events/csa-2018-fall-meeting
November 15-17, 2018	MEDNAX Anesthesia Leadership Conference	The Conrad Hotel Fort Lauderdale, FL	http://www.mednax.com/
November 17-18, 2018	American Society of Anesthesiologists Anesthesia Quality Meeting™ 2018	ASA Headquarters Schaumburg, IL	http://asahq.org/meetings/asa-quality-meeting
December 7-11, 2018	The New York State Society of Anesthesiologists, Inc. 72nd Annual PostGraduate Assembly in Anesthesiology	New York Marriott Marquis New York, NY	http://pganyc.weebly.com/

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