HEALTHCARE CONSOLIDATION

IMPLICATIONS FOR ANESTHESIA PRACTICES

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ASA District Director-Wisconsin

CONFLICTS AND DISCLOSURES

None
Former Regional Medical Director for TeamHealth Anesthesia (2015-17)

GOALS

Define and review healthcare consolidation
Market-based drivers
Implications for Anesthesiology practices
Strategies to adapt
HEALTHCARE CONSOLIDATION

Mergers and Acquisitions
- Between healthcare organizations and hospitals
- Between healthcare organizations
- Between payers and practices
- Between payers
- Between corporate entities and payers

VERTICAL INTEGRATION

Optum Care
- Surgical Care Affiliates: >1m patients/year in thirty states.
- DaVita Medical Group: 300 clinics in six states
- Advisory Board consulting business

CVS bid for Aetna
- 10,000 community 'hubs' for primary care
- Pharmacy benefit management
- Minute Clinics

Anthem/Cigna and Aetna/Humana

TOTAL US HOSPITALS

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<th>Category</th>
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<tr>
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TOTAL COMMUNITY HOSPITALS

SYSTEM VS. INDEPENDENT

THE HEALTHCARE SYSTEM FORECAST: FURTHER CONSOLIDATION

Deloitte forecasts that 50% of the healthcare organizations operating in 2014 will remain independent by 2024.

Consolidation evolving toward:
- Large national systems
- Regional systems with clinical integration
- Specialist Organizations
- Academic Systems
- Specialist Hospitals
HOW ABOUT HEALTHCARE?

Thirty hospital closures per year (AHA Annual Report 2018)
Morgan Stanley analysis (2018)

6000 US Hospitals
8% at risk of closing
10% considered “weak”

HEALTHCARE IS LATE.....

US HOSPITAL CLOSURES
HEALTHCARE ORGANIZATION M&A GEOGRAPHIC TRENDS: 2008-2016

- TX, CA, PA, NY, IL
  - Accounted for 30% of all M&A activity
  - Accounted for 39% of all M&A revenue

- MI, NJ, OH, NC, GA
  - Accounted for 20% of all M&A activity and revenue

M&A 2017

**Regional**
- Advocate and Aurora Healthcare (either largest system in the nation)
- Greenville Health System and Palmetto Health System (largest system in SC)
- UPMC acquires Pinnacle Health, with four hospitals in central PA

**National**
- Ascension and Providence St. Joseph
  - 191 hospitals, largest in the nation
- CHI and Dignity Health
  - 139 hospitals (Nonprofit Catholic system)
- Steward Healthcare and Iasis
  - 54 hospitals, largest private system in the nation
- Blackstone acquires TeamHealth
- Envision’s American Medical Response
- WebMD

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MILWAUKEE AREA ‘M&A’

2003
- Covenant Healthcare
- Aurora Healthcare
- Columbia-St. Mary's
- Froedtert and Community Health
- All Saints (Bucks)
- ProHealth Care
- United Health System
- Children's Health System
- Synergy Health (St. Josephs West Bend)

2018
- Ascension Healthcare (CSM, Covenant, All Saints)
- Aurora Healthcare
- Froedtert and MCW (Synergy, United)
- ProHealth Care
- Children's Health System
- Surgical Specialty Hospitals (MOSH, OHOG)

HEALTHCARE ORGANIZATION M&A

Average value of mergers increasing
- 2007: $42M
- 2013: $224M

Dynamics of mergers changing
- Strong acquiring the weak
- Merger of equals

WHY DO HCOS MERGE?

- Increase market share
- Increase efficiencies/Reduce costs
- Access to capital
- Improve quality and patient satisfaction
- IT/EHR
- Absorb mission-driven services
- Ability to create proprietary insurance product
REASONS TO MERGE.....

THE ACQUIRER.....
• Increase market share
• Patient access
• Physician network access
• Deliver care more efficiently
• Transition to value-based care
• Reducing risk
• Access to capital

THE ACQUIRED.....
• Access to capital
• HIT Systems
• Facilities
• Staff
• Equipment
• Deliver care more efficiently/Improve operations
• Increase market share
USE OF CAPITAL

MERGERS CREATE VALUE.....

IMPLICATIONS FOR ANESTHESIA PRACTICES

Loss of institutional memory
- Track Record
- Contracts

Payment based upon value
- Surgical vs. non-surgical options
- MACRA AND Third Party Payers
- Traditional subsidies disappearing
- Contracts reflect at-risk payment

Governance
- Need for new leadership structure
- Reward non-clinical activity
- Professional Development
LOSS OF INSTITUTIONAL MEMORY

Who are you?
- Past accomplishments matter less
- Fewer administration leaders know your group
- Personal/Professional

Actions
- Meet—and listen to—new administration
- Draft a resume for your practice

RELATIONSHIPS GET MORE COMPLEX

The hospital is part of a larger system
Your local CEO may not have the same influence
Multiple touch points to accomplish the same goal

Attorneys
- Finance
- Leadership blessing

Actions
- Understand new level of influence
- Find the right seat and the right tables
- May need to devote more time

CONTRACTS GET MORE COMPLEX

Master Service Agreements
- Consolidation of contracts
- Consolidation of stipends across practices
- Cross-subsidization across service lines

Actions
- Prepare for new negotiations
- Identify areas to align with HCO’s strategic plan
VALUE-BASED CARE: IT IS REALLY ABOUT THE TRIPLE AIM

Improve Patient Outcomes: Population Health
Reduce Costs: Direct and Indirect
Improve Patient Experience: Patient-centered focus in all actions

THE NEW WORLD

VOLUME-BASED
Fee for Service
Volume
Acute Episodes
Single Episodes
Prospective

VALUE-BASED
Outcomes
Value
Population
Care Continuum
Productivity

WHAT IS YOUR SYSTEM MEASURING?
SYSTEM PRIORITIES

- Patient-level outcomes
  - Mortality and morbidity
  - Functional status
  - Health-related quality of life
  - Patient experience of care

- Processes
  - Clinical protocols tightly linked to outcomes
  - Care coordination and transitions
  - Patient engagement and alignment with patient preferences

- Cost/resource use
  - Per capita cost
  - Total cost of care
  - Patient out-of-pocket cost

VALUE
Should drive everything we do and every decision we make

Value = Quality/Cost

Value = Quality x Service/Cost x Time

VALUE-PRACTICE PRIORITIES

Clinical Outcomes
Care Integration
Operations
Patient Experience
VALUE ALIGNMENT

How does my practice contribute to improved outcomes and better patient experience?
How does my practice measure costs and create awareness about costs among the physicians?
Does my practice reduce variation by standardizing clinical and operational protocols?
Does my practice impact key measures across service lines?

OPPORTUNITIES?

1. Cancer
2. Cardiovascular
3. Care coordination
4. Disparities
5. Endocrine
6. Functional Status
7. Gastrointestinal
8. GU/GYN
9. Healthcare Infrastructure
10. HEENT
11. Infectious disease
12. Mental health
13. Musculoskeletal
14. Neurology
15. Palliative & end-of-life care
16. Patient experience/engagement
17. Perinatal
18. Prevention
19. Pulmonary/Critical Care
20. Renal
21. Safety
22. Surgery

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RETHINKING WHAT WE DO.....ACTIONS

Clinical care models (Costs)
Expansion into new clinical services: (Population Health)
Evolution into new leadership roles (Alignment)
Improve HCAHPS and OAS-CAHPS scores (Patient Experience)

BARRIERS

Staffing and Internal Compensation Models
Culture resistant to change and/or risk
Lack of urgency
Time
Lack of administrative support
Physician stress

NO COST TOO SMALL.....

I was just shown the results for our first quarter. They were excellent. When mortals go through a prosperous period, it seems to be human nature for expenses to balloon. We are going to be the exception. I have just informed the purchasing department that they should no longer purchase paper clips. All of us receive documents every day with paper clips on them. If we save these paper clips, not only will we have enough for our own use, but we will also, in a short time, be awash in the little critters. Periodically, we will collect excess paper clips and sell them (since the cost to us is zero the Arbitrage Department tells me the return on capital will be above average). This action may seem a little petty, but anything we can do to make our people conscious of expenses is worthwhile.

Ace Greenberg, CEO Bear Stearns, 1978-1993; Memos from the Chairman (1985)
My friend had surgery here this morning and is currently a patient on the 4th floor. I just visited her in her room and she said that she has been blown away by the way she has been treated at Redmond. She lives in Kennesaw, but decided to consult Dr. Brock after multiple surgeries at Cleveland Clinic and several Atlanta hospitals.

She had high praise for Dr. Stanger. She said that she has NEVER had an anesthesiologist that treated her so well. He met with her and truly listened to her and made her feel at ease before her surgery this morning.

A 72-yr female patient is scheduled for elective THA four weeks before the day of surgery. She has a history of HTN, low back pain, and tobacco use. Weight 102kg. She takes Atenolol, Oxycodeine, and HCTZ.

The patient is directed to her internist for preoperative labs and testing, ordered by the surgeon.

Two days before surgery, a hospital RN checks the lab/test results and makes sure the chart has all the required paperwork. Abnormal labs include Hct 30 and Cr 2.0. EKG shows NSR with LVH.

The day before surgery, a hospital RN calls the patient, takes a nursing history, reviews medications (‘Just bring them with you in the morning’), and gives NPO instructions.

The morning of surgery, the assigned Anesthesiologist reviews the chart and meets the patient. She orders a T&S and orders Albuterol pre-treatment for mild wheezing, delaying by 20’ the time the patient goes to the OR.

In the OR, the patient receives an inhalational general anesthetic via OETT. She receives morphine as part of a balanced anesthetic. Intraoperative course relatively uneventful except for labile blood pressure. EBL~400cc.

In the PACU, the patient continues to receive morphine (up to 20mg) for significant pain. After two hours, she is transferred to the floor on 2L nasal oxygen due to fascial abscesses. The Anesthesiologist performs the postoperative evaluation at the time of PACU discharge.

On the floor, she is seen by Physical Therapy but cannot finish the first session due to nausea and dizziness. She continues to receive morphine through the night and Compazine for nausea. She continues to require oxygen to maintain O2 saturations. She receives one unit PRBCs.

On POD#1, the patient has her first PTx session. She is weaned off of oxygen and converted to oral analgesics on POD#2. She is discharged to a SNF on POD#4.

Her HCAHPS survey reflects an average score for pain management.
CAN WE DELIVER MORE VALUE????

Preadmission Optimization (Improved outcomes, reduced costs)
Clinical Protocols (Improved Outcomes)
Operational Protocols (Reduced Costs)
Management beyond Induction to Emergence (Improved Outcomes, improved patient experience)

NEW MODEL

A 72-yr female patient is scheduled for elective THA four weeks before the day of surgery. She has a history of HTN, low back pain, and tobacco use. Weight 102kg. She takes Atenolol, Oxycodone, and HCTZ.

Due to her history of chronic narcotic use, she automatically is placed into a high-risk pain protocol managed by the Department of Anesthesiology.

As part of that protocol, she is scheduled for an in-person visit that week to the hospital’s PAT clinic. At that visit, she is seen by an APN employed by the Department of Anesthesiology. Medications and plans for pain management are reviewed with the patient; labs and tests are ordered per standing protocol. She is counseled to stop smoking.

Lab and test results are reviewed by the APN the next day. Due to low Hgb, the patient is started on FeSO4 per protocol.

NEW MODEL

The day before surgery, the Anesthesiologist-in-charge huddles with OR management to preview the next day’s schedule. They together, identify three patients who will require heightened resources and/or attention the next day, and make the appropriate changes in staffing and equipment to meet those needs and coordinate patient flow. A RN calls the patient with instructions, including a reminder not to smoke on the day of surgery. The Anesthesiologist assigned to her care calls her the night before.

On the day of surgery, the patient takes her Atenolol as directed. Upon arrival to the hospital, she receives Albuterol prophylactically as ordered and is interviewed by the (AIDET-trained) Anesthesiologist assigned to her care. Transport to the OR and steps prior to incision do not vary, the result of a LEAN analysis the prior year.

Her intraoperative care is based upon protocol: she receives multimodal oral pain medication and an adductor canal block. In the operating room, she receives a SAB without narcotics (IT or IV). The surgeon injects the posterior capsule with LA. The patient requires no narcotic in PACU.
**NEW MODEL**

Postoperative pain management is overseen by the Department of Anesthesiology for 24-48 hours, until the SAB has worn off, the patient has transitioned successfully to oral pain medication, and she has completed initial PTx successfully.

The patient receives her first PTx session later that afternoon. She does not require a blood transfusion. On POD#1, her pain is well controlled on oral medication. She is seen by a member of the ACT and per protocol, pain management is transitioned to the surgeon.

She is discharged on POD#2 to an inpatient rehabilitation unit and goes home on POD#4.

1-2 days after discharge, the patient is called by the Department of Anesthesiology to conduct a short survey assessing her anesthesia care. Survey results are collected, reviewed, and used to make needed changes in care protocols.

Her HCAHPS survey reflects a high score for pain management. The AN group has an incentive-based contract to improve pain scores in high-risk patients having surgery.

She writes a letter to the hospital CEO about her anesthesia care.

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**QUALITY EVOLUTION IN ANESTHESIA**

- Poorly Defined Measures
- Process Measures
- Measurable Results (Compliance, Adherence)
- Patient Outcomes

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**NATIONAL QUALITY REPORTING**

- QCDR—Qualified Clinical Data Registries (accepts QCDR and MIPS measures)
- QR—Qualified Registry (accepts only MIPS measures)
- NACOR—National Anesthesia Clinical Outcomes Registry (reports for both QCDR and QR participants)
- AIRS—Anesthesia Incident Reporting System (PSO)
NEW QCDR MEASURES-2018

AQI 53 Documentation of Anticoagulant and Antiplatelet Medications when Performing Neuraxial Anesthesia/Analgesia or Interventional Pain Procedures
AQI 54 Use of Pencil-Point Needle for Spinal Anesthesia
AQI 55 Team-based Implementation of a Care-and-Communication Bundle for ICU Patients
AQI 56 Use of Neuraxial Techniques and/or Peripheral Nerve Blocks for Total Knee Arthroplasty (TKA)
AQI 57 Safe Opioid Prescribing Practices
AQI 58 Infection Control Practices for Open Interventional Pain Procedures
AQI 59 Multimodal Pain Management
Quantum 31 Central Line Ultrasound Guidance

ANESTHESIOLOGY MIPS MEASURE SET-2018

MIPS 44 CABG: Preoperative Beta-Blocker in Patients with Isolated CABG Surgery
MIPS 404 Anesthesiology Smoking Abstinence
MIPS 424 Perioperative Temperature Management
MIPS 426 Post-Anesthetic Transfer of Care Measure: Procedure Room to Post Anesthesia Care Unit (PACU)
MIPS 427 Post-Anesthetic Transfer of Care Measure: Use of Checklist or Protocol for Direct Transfer to Intensive Care Unit (ICU)
MIPS 430 Prevention of Post-Operative Nausea and Vomiting (PONV) – Combination Therapy
MIPS 463 Prevention of Post-Operative Vomiting (POV) – Combination Therapy (Pediatrics)

FPPE/OPPE ANESTHESIOLOGY MEASURES

Dental injury
Reintubations
Failed intubations
Unanticipated ICU admission
Narcotic reversal frequency
Anesthesia complications
Patient complaints / grievances
VALUE DASHBOARD
Clinical Measures
Operational Measures
Cost Measures
- Blood and pharmaceutical usage
- Preop testing
Surveys
- Patients (internal or external)
- Surgeons

TAKEAWAYS
Value-based care is the future
Population health and total cost of care are critical elements
Contribute value across service lines and conditions
Document your value-based practices
Registries and FPPE/OPPE are mechanisms to report and drive quality

LET’S FINISH WITH INFRASTRUCTURE....
Infrastructure basically is the resources—people, technology and processes—necessary for a practice to conduct its business.
“Everyone in healthcare should have two jobs: to do the work and to improve how the work is done”
- Maureen Bisognano
- CEO, Institute for Healthcare Improvement (2012)
QUESTIONS
What is my practice’s governance structure? (Leadership)
Does my practice support both clinical and non-clinical work? (Alignment)
Does my practice relentlessly look to improve quality and cost efficiency? (Focus)
How does my practice define and reward performance? (Compensation model)
Does my practice participate in risk-sharing agreements (Value-based payment)

REDESIGN GOVERNANCE
Key Concept: Value is created at both the individual and group levels
- Leadership
- Designate Champions
- Support Physician Professional Development
- Promote ASA/WSA Membership

LEADERSHIP POSITIONS
Director of Quality
Director(s) of Service Lines
Ancillary Services (Midlevel Providers)
Perioperative Services (Operations)
Basic Finance (The Numbers Guy)
AIMS
SERVICE LINE OWNERSHIP
As a proxy for population health
- Cancer Care
- Cardiovascular Care
- Orthopedic Care

Anesthesiologists as service experts:
- Cost drivers: anesthetic and non-anesthetic
- Complications
- Payment methodologies

PROFESSIONAL DEVELOPMENT
Support beyond ‘CME’:
ASA and non-ASA Conferences
Ad Hoc Coursework
System-Based Education

Support practice leaders to develop new skills!

CONSOLIDATION TRENDS-SUMMARY
Continued hospital and health system consolidation is poised to remake the delivery system landscape over the next 10 years. Both market and regulatory forces are driving consolidation.

Mergers include both Large acquiring Small, and mergers of ‘equals’

Movement toward three types of systems: national, regional and academic

System focus upon triple aim: improved outcomes, increased patient satisfaction, and reduced costs

Value-based system contracts for anesthesia services
ADAPTING TO A VALUE-BASED WORLD

- Recognize that relationships will change
- Align practice and hospital/system goals
- Expand your presence in the supply chain
- Document your contributions to value; focus relentlessly on costs
- Build a group infrastructure that supports both individual and group contributions to value
- Support Advocacy at state and national levels