Epic Systems - Former System Vice President of Orthopaedic Services at Baptist Health System

Interview conducted on January 03, 2023

Topics

Healthcare Operations, Value-Based Care, Data Analytics, Payer-Provider Communication, EHR Systems, Gaps in Care, Epic System, Healthcare Software Platforms

Summary

The Tegus Client spoke with a former System Vice President of Orthopaedic Services at Baptist Health System about the challenges of managing revenue in value-based contracts, identifying gaps in care, and preparing for the transition to value-based care. The former VP emphasized the importance of establishing metrics and utilizing analytical tools like Qlik and Tableau to extract information. They also discussed the limitations of current EHR systems and the need for better mechanisms to understand what is happening outside the four walls of a healthcare system. The expert believes that there is a need for a back-and-forth dialogue between providers and payers to address these issues.

Expert Details

Expert is the System Vice President of Orthopaedic Services at Baptist Health System, a customer of Epic. The Expert oversees the team of Analysts focused on the Orthopaedic data for the health system.

Expert is the System Vice President of Orthopaedic Services at Baptist Health System, a customer of Epic and Clicker. The Expert oversees the team of Analysts focused on the Orthopaedic data for the health system. The Expert notes that they don’t have a strong technical background, but they can speak to the use case of their products as well as the value that it brings to the organization.

Prior, the Expert was the Director of Finance and Administration of the Department of Orthopaedic, leaving February 2020.

Q: Can you speak to industry trends on Value-Based Care, and how that affects the administrative workload associated with data transactions between payers and providers?
A: Yes, I can speak to general industry trends and data transactions.

Q: What are the main levers used to streamline transaction-related administrative work? Can you name the top 3 platforms?
A: This is dependent on the type of transaction and could shift across platform priorities. We are avid users of Epic and Clicker,

Q: Do you see a value beyond administrative cost reduction for these tools? Can you discuss this in depth?
A: Yes, I can speak to this as there are many other values after admin cost.

Q: (customer) What is/was your annual spend for the product?
A: .

Tegus Client

Thank you for taking the time to speak with me today about the administrative burden associated with the

state of the health care industry, particularly related to revenue generation, coordinating payments from payers as well as patients and some of the complexity generated by value-based contracting as well as managing, tracking and reporting of quality metrics. To start off, could you please give me a quick overview of your background and experience in this space?

Former System Vice President of Orthopaedic Services at Baptist Health System
Okay. My most recent position was with Baptist Health. And in that role, I was the System Vice President of Orthopedics and Neurosciences. So I had responsibility for orthopedic, neuroscience activities at like nine locations for the system.

So if it related to operations, finance, dealing with value CIN metrics. I mean, you name it, it fell to me. So I do have experience in this realm from a large system standpoint and can speak to some of the complexities involved with revenue generation, value-based contracting and the system perspective on preparing oneself for that journey.

Tegus Client
Okay. So what were the top priorities as a leader in a provider system when it comes to facilitating revenue generation as well as maintaining quality? What would you think of as the top three or four priority for your systems? What are you concerned about? And what are you looking to optimize?

Former System Vice President of Orthopaedic Services at Baptist Health System
The top priority that we were dealing with during my time there was establishing the metrics that we would use as the benchmarks for the organization for everything that you just mentioned. Baptist is somewhat of a loose confederacy of nine hospitals. It's not, by any definition, a cohesive medical system yet in that you've got various stages of maturity between the various locations.

Some are much more developed, much more savvy. The smaller locations, not so much. So you're dealing with a wide geographic area differences and the savviness of the specific sites and then the overall savvy of the organization in terms of extracting data. Baptist utilizes Epic, which is one of the largest systems out there.

And Epic is very good at capturing just an enormous amount of data, but the particular reports within Epic don't do a good job of extracting all of that information. So if you're wanting to do an in-depth dive on, let's just say, your reimbursement for a specific procedure Epic in and of itself does not do a good job of breaking down those functions. So you've got to look at a third-party platform. We utilize Qlik there to get in and really break down the information.

The larger an organization, any organization of that size or similar is going to face the same difficulties in, one, determining what metrics you want to follow. And then two, going about the process of extracting that information. So that was the biggest issue that we felt in relation to the topic today. Provider buy-in was also a very large topic that we had to deal with because in that environment, the providers were employed, and there was really no incentive and no way of controlling their behavior, if you will, from the act of delivering care.

So you had some providers, and I'll just use a joint replacement example here that were using a $4,500 hip and some providers that were using a $9,000 hip. And there was really no direction or action that hospital president or anyone could you to tell the doctors, hey, why are you doing this? So we went down an extremely lengthy process of determining what we wanted to measure.

There were no scorecards or dashboards for the orthopedic and neurosurgical service lines when I started. So I was fortunate enough to work with an analyst. And for the orthopedic scorecards, we started with a list of 286 items out of Epic that we could possibly utilize. And then over the course of several months, got that down to 60 or so and then finally whittled that down to 12 because on the scorecard visually, you only have room for 12 columns.

So it took a lot of conversation with the doctors to say, this is what we want to do as a system. And I said, hey, everybody understand that the various facilities are at different stages of their journey and we were

able to get it down to 12. And even within that, it took several months of conversations with the providers to get buy-in for them. Some of them would say, oh, I can't be that expensive. Well, yes, and here's why.

So that was probably the biggest one. Dealing with hospital presidents in enforcing service line mandates was also another issue. The presidents were essentially concerned with maintaining and preserving their revenue streams, and they did not want to upset their very busy surgeons who brought in lots of revenue to the facilities. Found out that the hospital presidents were actually ignorant of the cost structure for providing the services that I oversaw.

So when we develop those dashboards, we share them with everyone. We blinded them for, I think, two months and then took the blinders off and that was a very interesting conversation with both the orthopedic and the neurosurgeons regarding the cost issues. But we did that not from a punitive standpoint, but just to show that, hey, there is a tremendous opportunity here for cost and quality improvement.

So from a cost perspective, we looked at the major orthopedic procedures, your hip and knee replacements, your revisions. From a neurosurgical standpoint, we looked at the fusions because from Baptist's perspective, the overwhelming majority of the implant spend came from fusion procedures and went about it that way.

Tegus Client
Yes. So you mentioned layering on this third-party app Qlik to provide the higher order view. And a lot of the things that you're relaying are the overall metrics of how providers and systems are doing. These sound a little bit like they're something you would look at more retrospectively, at the end of the month, end of the quarter to see hospital X had 20 or 200 procedures at this cost versus hospital Y, some other numbers. Am I understanding that correctly? Or was it more of like a real-time visibility?

Former System Vice President of Orthopaedic Services at Baptist Health System
Well, we were in the process of taking it from a retrospective to a proactive current actionable items that we could give. I really cannot understate the amount of time and effort it takes to build these dashboards and scorecards. So I mean if you're just looking at a singular hospital with a couple of doctors that are doing this, it wouldn't be that long.

But with a large system like Baptist, especially in a smaller rural state, there are so many more complexities that come about because at least in Baptist's example, their contracts are different. So the reimbursement of different cities are different. The implant pricing is different across the organization as well.

So what cities pay are different and so on. So it takes a tremendous amount of work to get the data extraction to the point where you can comfortably say, okay, I know that the Zimmer Biomet dual mobility primary hip in one place, let's just say, is $9,700, and then just going about it that way. So the exercise revealed a lot of inefficiencies within the system that we were in the process of fixing.

But again, when you're talking about a nine-hospital system with presidents that are fiercely defending their surgical territory, it's not something that happens overnight. If you've got a system that is in lockstep across multiple locations, that build process would be a lot easier. But our ultimate goal was to get a scorecard that on a very high level, looked at your key procedures. In my realm that was primary hips, primary knees and spinal fusions.

And with that, we were then able to start digging down into the various cost and structure within those procedures. So when we first started, we just said, okay, what's the total cost for a primary knee, let's say. And then we looked into all the various elements that contributed to that number. So your direct cost per case, your OR minutes, your nursing care, your pharmacy care, your PACU pre-op per case, your lab cost, your PTOT case, your imaging per case and your direct chargeable supplies. And we put all of that out there.

Tegus Client
Yes. So if you're focusing specifically on major joint surgery, ortho as well as some neuro. And because these are procedures that are largely under a significant amount of utilization management from payers. Is that correct?

Former System Vice President of Orthopaedic Services at Baptist Health System
Yes.

Tegus Client
Well, you wouldn't necessarily have the same level of overview or control for procedures that were less subject to utilization management whatever those may be? But was this driven by bundle?

Former System Vice President of Orthopaedic Services at Baptist Health System
No, it was not driven by bundles. Baptist wasn't participating in a single bundle when I was there, that was the ultimate goal. But when I came and realized the inefficiencies within the system, I knew that there was no way that we could sign on to a bundle right then because you have to have complete and total mastery of your cost structure before you can even engage in those conversations.

We had a couple of major insurance carriers approach us to say, hey, we're interested in doing a bundle. For example, we'll give you $23,000 in entirety for a total hip. And when I got there, it was like, I can't tell you how much it costs us to do that. So it was a very lengthy journey of developing that cost structure. And again, Epic was not sufficient to help us with that.

So any major system that's going down this path itself is going to have to have a Qlik or a Tableau or some of those similar projects to really get in there and get down to a category level spend. Now this project also got us to looking at the number of implants used. So for example, in our neurosurgical space, we were purchasing items from 153 separate vendors.

And in working with our supply chain counterparts looking at the actual items because I mean, if you talk to a surgeon, a plate is a plate, a pin is a pin. So why are we buying them from nine separate companies? So we were able to whittle that down and eliminate over 50 companies just right off the bat and consolidating more of that purchase with Medtronic. So we were in the process of doing that with Baptist as well. But again, it is such a tremendous project in terms of size and scope and deliverables that it honestly takes years to complete from inception to finish.

Tegus Client
So this was an initiative really driven by the desire at Baptist to have a better visibility and control on cost to deliver care. Is that fair? This is really like an initiative taken on by your own system. But what's the driver behind that? I would say that America is a fee-for-service system, why do you care? As long as you're getting covered for payments paid by the insurers, why does it matter? Was this done with the vision of into the future, we're going to have to move to value-based care or bundle?

Former System Vice President of Orthopaedic Services at Baptist Health System
Absolutely. Because unless somebody has been living under a rock, the whole fee-for-service is going to go away at some point. Nobody has a crystal ball to say, okay, July 31, 2027. But at some point, that's going to occur, and people are smart enough to understand that, hey, this is going to be a Herculean shift in how care is delivered.

So five, 10 years ago, even now to a degree, you really don't have to be in total mastery of your cost and quality structure to have money coming in the door, but that's going to change. So it's incumbent upon those in the health care to realize, hey, I've got to change. I have to look at every procedure that I do. We started with the major ones just because of the frequency and the percentage that those procedures played within the various service lines, but you can use that same thought process for your minor procedures.

Because when you look at the total number of procedures who's in, let's say, under 50 a year per facility, when you're talking about nine hospitals, the number of those adds up considerably. So we weren't going to just stop at the top three procedures. We were going to roll this out throughout the service lines at all nine locations for all surgical services.

Tegus Client
I want to shift gears a little bit and chat, it sounds like from your experience at Baptist, a lot of work around

building these capabilities and tools to understand internal activities and spend across the spectrum of what was happening clinically for an individual patient. This shift towards thinking about the visibility, not just within the system and within physicians and what they're spending, what other physicians are doing with their individual patients.

But also conversely out towards the patient's health insurer. But what if Baptist was doing anything in order to facilitate that type of data, whether it be clinical or financial claims-based transaction back and forth with insurers and payers? And could that be related to things like just submitting claims? I think about things like large joints, also things like prior authorizations. So can you talk to me about whether or not anything that you were just speaking about also facilitated that engagement communication with insurers.

Former System Vice President of Orthopaedic Services at Baptist Health System
Absolutely. There were areas within Baptist that were solely dedicated towards payer relations, and there were constant conversations between the organization and the Baptists, the Humanas, the all of those. Those organizations are acutely aware of the transition within health care away from fee-for-service to more of a value based. And my perception is that the payers are well aware that the facilities, the providers, the systems are not ready for that transition.

So they're just quietly awaiting and doing whatever they can to assist the health care providers down this path of transitioning. So we would have conversations with, say, a Blue Cross Blue Shield and Anthem, Humana to say, okay, this is where we're headed. And you honestly have to crawl before you can walk. So some of the CIN metrics, the value base that we put in were fairly rudimentary. Like your smoking cessation, your body mass indexes, things of that nature.

But the understanding was that over time, those indicators would become increasingly difficult to achieve from an outcomes perspective because at the end of the day, a Blue Cross Blue Shield or Humana is not going to be satisfied with smoking cessation for the entirety of the relationship. You've got to start looking at your length of stay, your 30-day readmissions, your 90-day readmissions. Your complications, the surveys that the patients fill out regarding their return to a normal life, things of that nature.

So that was all part and parcel to what we were trying to do. Prior to this, I was with a University Health Science Center, and we worked very closely with the university hospital system. And I will say that the rural markets seem to adopt things a little slower than your major metropolitan areas. Prior to that, I was in a state in the South, and we were honestly several years behind what you were finding in the literature about trends in health care.

So I'm sure that as you continue down your journey and talk to people with systems in various parts of the country, they're going to be at different stages of the journey for this. But again, we were in constant communication with the providers about what we could do to help prepare ourselves for the transition away from fee-for-service care.

Tegus Client
Okay. So from what you've seen, has there been a mechanism to actually pull in information from insurers about patients that helps you to deliver better care?

Former System Vice President of Orthopaedic Services at Baptist Health System
We did get some information from the payers about the outcomes that we had. But in my situation, it was more focused on the internal development of dashboards and standards because Baptist had no way of knowing if the information, let's say, Blue Cross came back to us with matched our own experience. So if they were saying, oh, we're seeing significantly higher readmission on your primary hip replacements in females aged 80 and above.

We had no way to say yes or no to that. Now we thank them for their information. But again, it was all about that internal data development just to give us an understanding of where we were because again, prior to my arrival, they had no dashboards and essentially no understanding of where they stood from a quality perspective.

Tegus Client
What you do to the dashboard? Did you end up having more aligned view with the payers? Or were there still pretty significant differences in terms of outcome?

Former System Vice President of Orthopaedic Services at Baptist Health System
We were getting more aligned with the providers on that. We found a number of discrepancies in the data transmission process, which we rectified. But again, during my time there, it was more towards the initial stages of that development. I would recommend that you've got to have communication between the provider and the payer to make sure that both sides are on the same page and have a robust dialogue to say, hey, we've developed this internal dashboard, and this is what we're seeing.

Now with Tableau, with Qlik, you should be able to get it down to payer-specific levels, by patient, by implant, by fuse, so that you can narrow it down to determine if it's a particular implant that is the cause. If it's a certain doctor, it's a certain length of stay, if it's a certain medication and if it's a certain whatever because the data is in there, you just have to have the means for extracting that data out of whatever repository it resides in.

Tegus Client
It sounds like the process, at least during your tenure there, though, was or the dialogue with the payer and your group was pretty, I want to call it manual ad hoc. You would have a meeting. They would come in once a month or once a quarter with their results and walk you through them and then maybe you'd bring in your results. So there wasn't anything in the way of a kind of an automated data transmission process or data analysts and things like that. It really was everyone bringing their dashboards into a meeting and talking it through. Have I got that right?

Former System Vice President of Orthopaedic Services at Baptist Health System
That's right. We were starting from ground zero. I mean, the only thing that Baptist did prior to my arrival was just hit the push button to send out all the claims. I would say that all of your major payers are desperate to have those conversations with the systems, the hospitals, the providers on the quality. But in my experience, and I've worked in many areas,, most of your systems are not savvy enough to mine their data to a level that would please the payers.

Because up to this point, they've never had to. You just hit the send button, out it goes and then you get whatever reimbursement you've got. So maybe this is through fault of their own, but they've never, in my opinion, a majority of the providers out there spent the time developing the internal analytics to look forward to say, hey, at some point it's going to change. I don't know exactly when. But they've not spent the time in investing in the analytical capabilities of the organization.

Tegus Client
And again, in the environment you've worked in, the degree of risk taking accountability still is, I think I heard you say is relatively immature. So frankly, providers haven't really had the incentive to try to develop these analytics and line up with the payers about what's going on because they were still being paid.

Former System Vice President of Orthopaedic Services at Baptist Health System
Absolutely.

Tegus Client
As that world towards value-based care evolve, then providers are now scrambling launching multiyear projects like the one that you were doing to try to line up and have a common view with the payers about what's going on and start to identifying service opportunities for improvement?

Former System Vice President of Orthopaedic Services at Baptist Health System
Yes.

Tegus Client
Did you find different payers at all? I don't know if you got to that level, but different payers were more mature, more energetic, more sophisticated. I mean was Humana more sophisticated that the local Blue, United?

Former System Vice President of Orthopaedic Services at Baptist Health System
Humana, I don't feel is as sophisticated at least to your locally Blue Cross Blue Shield. Well, United, we just had some very preliminary conversations, but the items in which they were seeking seem to be a bit rudimentary. So I really wouldn't give them high marks. And that's really all I can recall.

Tegus Client
Can you speak to the items that they were seeking not being sophisticated? What you see as a sophisticated thing to track versus a rudimentary doesn't really get to the outcome, but it's a box to tick?

Former System Vice President of Orthopaedic Services at Baptist Health System
For example, with Humana, they just threw out a cost. And I think it's maybe the mid-20s for hip replacement. But in the conversations that I had with them, I did not pick up on any concern about reducing length of stay, about readmissions or infection rates, it was all about a dollar exchange for a service. And that is a component of the patient experience.

But from an overall cost perspective, if you've got people coming back at a two times higher than normal rate for post-op infection or swapping implants out that adds tremendously to the cost. And I was somewhat surprised that there really wasn't any focus or conversation on that because, again, their primary or initial procedure is very important, but you don't want them coming back for pretty much any reason.

Again, there was really no mention of that. So to me, that cost of, hey, if we can get them to sign this contract a bundle for 20-whatever-thousand it was for primary hips, we're going to save a bunch of money. Well, not really because you're just focusing on one tiny element of the overall experience.

Tegus Client
Yes, this makes me start to wonder about as well as one could imagine, there could be specific implant types or locations that, for example, have a much higher rate of rehospitalization, revision. I would imagine there are also some controls around trying to softly or hardly steer the selection of what is going to be done.

And so my mind first goes to prior authorization. And we've heard it commonly, the bane of many physicians or clinicians experience, particularly around things like large joint. And there's a lot of newer tools and applications around automating or facilitating that process to make sure the right clinical data is already collected and ready for the various insurers. Did your experience at Baptist, were you using any tools to facilitate prior authorization requirements?

Former System Vice President of Orthopaedic Services at Baptist Health System
There were some payer specifics that we were using, and I apologize, I don't recall those. But yes, what you just spoke to is a big concern with the orthopedic surgeons and the neurosurgeons as well when it comes to getting procedures authorized. So if what you're doing is working towards that, and I know that the providers would love that.

But there was nothing they hated more than getting a call from their surgery scheduler saying, hey, you didn't do this, you didn't do that for the authorization. So that was a huge issue. The payer management, they absolutely detested. So whatever one can do to make sure that all the necessary boxes are checked, every I dotted and T crossed, would be a huge win for the providers.

Tegus Client
Okay. You've highlighted that Epic tools were insufficient to manage everything that you were looking for with doing your own internal analytics but also presumably that follows as well for those communications with insurers. Is that correct?

Former System Vice President of Orthopaedic Services at Baptist Health System
Correct. If you look at a Cerner or an Epic or an eClinicalWorks, I mean, these programs are designed for global functions. And at some point, the software developers have to put a stop on to how much they're going to develop this. So that's where you get your Qliks, your Tableaus coming in because the information is within Epic.

So when I talked a few moments ago about the various components of a primary joint, the cost per case, the OR time, the nursing routine care, the pharmacy. All that information is in there, if you're looking at pushing a product like Epic out, at some point, you've got to stop and say, okay, this is enough. So again, for any meaningful data dive in there, you've got to go so much further than what an Epic, a Cerner and eCW offers, and that's created the niche for those secondary companies to come in and go in and extract that information.

Tegus Client
Are you familiar with some of these Epic payer platforms?

Former System Vice President of Orthopaedic Services at Baptist Health System
Yes.

Tegus Client
So what exactly Epic payer platform can do? And why it's not enough once we get into specific clinical areas, which is what I'm surmising from you?

Former System Vice President of Orthopaedic Services at Baptist Health System
To me, it's more of a marketing gimmick. It goes above and beyond what a normal platform can do. But from an organizational perspective, it comes down to a cost benefit analysis. So from Baptist's standpoint, they said, okay, we've already got Epic. We can look at this additional platform offered through them or we can look externally to see what other options are out there.

In Baptist's case, it made more sense to go with Qlik because when we looked at the amount of resources internally dedicated towards the Epic product or Qlik, it was much better going with Qlik. And then also when you look at the robustness of the product that you can develop with Qlik, it just made a lot more sense. When you start getting into those Epic add-ons or Qlik, you're dealing with additional FTEs, additional resources required to run those.

So in my role, I never ran a Qlik report. I had somebody dedicated to me to do that because you're actually starting to get into software writing when you get down to that level of analysis when you're looking at your three-hole spinal plates or whatever it might be. So it was a cost benefit analysis for us. And from what I've seen on the Epic additional products, I would recommend going forward with a Qlik or a Tableau because I just didn't see the bang for the buck in what Epic was offering.

And again, when you look at the scope of what Epic offers, I'm not sure that they will ever develop a product that can match what I've seen in Qlik or what people can do in Tableau just because they've got such broad interest in the existing product they have.

Tegus Client
Is Qlik mostly an analytical product because you're comparing to Tableau? I think of Epic payer platform as being more of an interface, which allows for easier and automated data transmission back and forth between payers and providers.

Former System Vice President of Orthopaedic Services at Baptist Health System
Yes. I look at Qlik as an analytical tool to help us in that. In my conversations with our payers, we weren't ever able to iron out the true functionality with Epic for those modular add-ons. So from my perspective, I never got the sense that it really added the value that Epic claimed it would.

Tegus Client
Got it. But it sounds like it's more of an analytical module to help you understand the Epic data.

It wasn't about building pipes or more automated pipes to the payers because your discussion with the payers was, as we talked about before, largely through meetings and sharing PDFs back and forth and maybe Excels, but not in any way automated data flows or anything like that. Am I thinking about that the right way?

Former System Vice President of Orthopaedic Services at Baptist Health System
Yes. We were in the process of working on the automated data flows within Baptist out to Epic. But during my time there, we weren't able to iron out those issues with them.

Tegus Client
Got it. And so everything was Epic's expense?

Former System Vice President of Orthopaedic Services at Baptist Health System
Yes.

Tegus Client
Okay. I'd like to shift gears to the need to manage revenue in more of these value-based contracts. And I think a lot of things that we hear people being concerned about are things like gaps in care and closing those gaps in order to theoretically prevent disease progression and higher cost care needs into the future. And so does the system that you had internally with the version of the medical record that you have for your providers, facilitate them identifying gaps in care and closing gaps in care.

Former System Vice President of Orthopaedic Services at Baptist Health System
We were starting down that process when I was with Baptist because as I spoke a little while ago, we understood that the current environment is going to change. So we were in the process of setting up what we thought we needed to do to prepare ourselves for the journey. Within Baptist, you've got nine hospitals. I'd say probably 99% of the world has never even heard of the smaller ones. And the level of care, the staffing were night and day different. I wouldn't say the level of care, but the staffing, the infrastructure it was night and day different than at your larger facilities.

So when we talk about gaps in care, I think that's going to be largely dependent upon where you're located because some of our facilities didn't have a single neurologist. Some of our facilities didn't have a single neurosurgeon. Some of our facilities only have one employed orthopedic surgeon. So the value-based contracting there is going to be one of the last thoughts.

But when you look at your larger markets or some of the other facilities, which I'm sure you're talking to with other people, they're going to be much further along that journey. And we had those conversations with the payers just to let them know, hey, quite honestly, we can look at some value-based contracting for the larger metropolitan markets. But we had postings open for providers in some of those smaller markets for over four years, so there was really no way that we could put a value-based contracting into memoriam with the payers for those smaller markets.

Tegus Client
So what I'm hearing then that in the absence of a value-based contract, there is just a lack of interest in addressing gaps in care.

Former System Vice President of Orthopaedic Services at Baptist Health System
There's not an issue in addressing it, but when you look at the realities of finding providers just a very basic bread and butter of providing health care, a lot of these smaller rural facilities can't even do that. So for them to be in a point, well, hey, let me sign this value-based contract I don't see how they would do that.

I can only see really your larger, more sophisticated systems facilities in larger metropolitan areas where you

don't have to worry about recruitment being an environment where they would be willing to sign a value-based contract because again some didn't have a neurologist. They only had one orthopedic surgeon, but he's in his 70s, they didn't have a neurosurgeon.

Tegus Client
So even in the absence of a value-based contract, though, the level of gaps in care, in theory, if there are fewer of them that are open, the actual overall outcomes for your patients will be higher, which would result in a higher quality rating overall, which would change your positioning in the network. So even in the absence of an actual VBC.

Former System Vice President of Orthopaedic Services at Baptist Health System
Yes.

Tegus Client
What I'm hearing from me is a lot of discussion. But not at all answering whether or not you did anything to work on gaps in care and how you would identify them. Do you work on them?

Former System Vice President of Orthopaedic Services at Baptist Health System
We worked on gaps in care from a systems perspective and then we also worked on that from a service line perspective. So let me backtrack a bit. There is interest in providing the best patient experience possible. There's no doubt about that. But for example, the hospital president is saying, I can't even get a neurologist to come down here on a locum basis, I can't enter into this.

And I just threw neurology in there, but that could be any of your specialists. A lot of these smaller hospitals just don't have it. If somebody comes in with pancreatitis on a weekend, but it's an immediate transfer out. So these smaller hospitals are dealing with these issues, but it's not from a lack of interest. It's just from a lack of infrastructure and capabilities in staffing.

Tegus Client
Okay. And so for those facilities that do work on gaps in care, is this entirely the existing issues identified through your internal medical record systems? Or is there any input pulled from the member's insurance plan?

Former System Vice President of Orthopaedic Services at Baptist Health System
Actually a combination of those. We would have conversations with payers, and they would let us know that, hey, this is an issue. And I talked about the recruiting issue a little while ago. We also did quite a bit of introspection on our own, say, hey, where are our gaps?

And we would do that through our strategic planning process and looking at the information that we would get out of Trilliant and the Kentucky Hospital Association for the discharge transfer data to say. So we're noticing that a large number of patients from this ZIP code are seeking treatment at, say, UK over in Lexington when we've got a facility ten miles from there, who's not seeing that.

So that was something that we did constantly. And then we would work internally on identifying the space and putting a recruitment plan together to address those needs. It wasn't as formalized as I would have liked from a system perspective, but we were doing that on a facility-by-facility basis.

Tegus Client
Okay. And the status for those just reviewed on a quarterly basis?

Former System Vice President of Orthopaedic Services at Baptist Health System
We would actually talk about those on a monthly basis. I would have conversations with the service line leadership on a monthly basis, and we also had monthly service line meetings where everybody would get on to Zoom, and we go through our standard financial volumes, quality issue and then talk about the growth

and development phase of that, and that's where we would put those items.

Tegus Client
And so would that then be the opportunity to engage and prompt the individual providers about gaps in care on that monthly meeting? Or was there any other more immediate intangible prompt for them?

Former System Vice President of Orthopaedic Services at Baptist Health System
We did that on a monthly basis. We got someone in quality towards the end of my time there, but we would use that opportunity to say, hey, this is what we're noticing. Can you offer this procedure? What do we have to do to get somebody down there twice a month to have a clinic and operate? So we did discuss that on a monthly basis. And again, it wasn't as formalized as I would've liked, but it was my hope that we would get to a more formalized basis.

Tegus Client
Okay. But it doesn't sound like there would be anything. I would imagine the optimal time to prompt a physician about a gap in care is in the moment when they're actually seeing a patient. And so whether or not with your system, you would develop anything to in the moment and nudge a clinician of, oh, you're seeing ABC today. She actually hasn't had cancer screening this year.

Former System Vice President of Orthopaedic Services at Baptist Health System
Yes, we did build prompts within Epic. The recommendations on smoking cessation, colorectal screenings, things of that nature. And that was in a different area than what I worked with. But we did do that and that was more on a primary care basis to build items within Epic for those annual wellness visits to say, okay, have you had your flu shot? Have you had a tetanus within the appropriate time frame? And it just went down the list. But yes, as an organization, we did address those.

Tegus Client
Okay. So regardless of having the rates of gap closure in VBC. Are they the kind of thing that you would actually have discussion with insurers on a regular basis on the status of those? Or is that just something that was the status was transmitted in the background through the various data pipes that we were alluding to earlier?

Former System Vice President of Orthopaedic Services at Baptist Health System
No, we would have conversations with the payers, and I was in a couple of those calls where it wasn't formalized, but we would relay to them that, hey, we've added this screening question to the annual wellness visits. And the annual wellness visits are how Baptist chose to address those issues. And there were certain items in there that the specialists would talk about upon the specialty.

For orthopedics, smoking cessation and obesity, your body mass index were two of the high issues that we were talking about. But all of the specialties within the organization had the various questions in addition to what the primaries would ask on those annual wellness visits.

Tegus Client
Okay. And if you take a step back and think about these tools, particularly when you think about the data pipes, in a blue sky state, I could imagine an ideal world wherein there would be the seamless and immediate transmission of the state or status of an individual patient. And the payer would have all their clinical history and wouldn't have to ask specific questions in order to approve or deny a prior authorization for a certain procedure. How far do you think the systems are from that ideal state today?

Former System Vice President of Orthopaedic Services at Baptist Health System
I think we're probably several years away from that. At least within the environments that I have worked, the process of changing the internal workflow is considerable. So for example, at Baptist, if they wanted a change to Epic, let's say you wanted to add another box to check into an annual wellness form. That was usually a four- to six-month process because you've got to go through various committees and whatnot.

At my prior job, it was the same thought process that you've got to take it through a committee and whatnot. So it's just such a laborious process to modify the internal workflows. And I think that's probably the biggest hindrance towards blue sky that you were talking about because certainly, a majority of that information is there. But when you're talking with multihospital systems, the bureaucracy is such that things move at a glacial pace.

And I don't agree with that from an outcomes of performance perspective. It's just unfortunately the reality in what I've seen in, I think, five states of working with health care providers now. I think there's a tremendous willingness from the payer's point, but the providers aren't savvy or sophisticated enough to pull their end in that equation.

Tegus Client
Okay. So you've mentioned repeatedly this Qlik as a platform that helps facilitate your understanding of performance internally. Do you think into the future of those platforms that kind of layer on top of the EHR are going to continue to be the vehicle that really drives us? Or do you see that as something that eventually is going to either be purchased by one of the large EMRs or something that is going to eventually expand?

Former System Vice President of Orthopaedic Services at Baptist Health System
Well, I think you're going to have a couple of those small external providers continually there, but I could see an Epic, a Cerner, an eCW acquiring a Qlik or something else or developing their own products internally. Because again, I've not come across an EHR yet that I think has hit a home run or knocked it out of the park.

There's just so many nuances within health care analytics that one can go down that I think it's going to be impossible for eCW, Epic, whoever, to build that internally. So that need will continue. And again, I wouldn't be surprised if an Epic or somebody, GE, purchases them and builds that internally, but that need is going to be there constantly.

Tegus Client
Okay. And do you feel that you get enough information from your patient's health insurers about the state of their health care? And one can imagine any individual patient may actually seek care outside of your system. And in theory, their claims are always going to be submitted to a single payer. And so in theory, that insurer will have the global view of an individual's health.

Do you feel that in today's system, you have sufficient visibility of what is happening with an individual beyond the four walls of your institution?

Former System Vice President of Orthopaedic Services at Baptist Health System
If we inquired, we could get that information, but that level of information was not routinely shared or it was not shared on the phone calls and the meetings that I participated with in the payers. They could give you very broad overviews but not getting down to specific levels. Now I'm sure that they have that information, it may just not have been the appropriate time to relay that.

But again, I was always impressed with the payer's information and their understanding of where their patients were going. They're further ahead than the providers are at this point when it comes to knowing where the patients go. At Baptist, at the university hospital in Texas, in South Carolina and Florida, all of the systems that I worked within for did a very poor job of tracking the kept and leakage data.

So we could tell you how many patients didn't come back or patients in our ZIP code that went elsewhere or if we had a capitated plan that shows to go elsewhere, but none of the systems were able to really dig in and figure out why. It always seems to be a very low priority for a system to keep track of that information and start taking actionable steps towards reducing those leakage numbers.

Tegus Client
Yes. So it sounds to me then that there is not a mechanism for if I'm an individual provider and let's say, I'm concerned about a patient, I think they need a joint replacement. But I want to understand have they actually already had an x-ray, undergone PT anywhere beyond just what they're telling me. So is there a

mechanism for you to understand what's happening if it's outside the four walls of your system?

Former System Vice President of Orthopaedic Services at Baptist Health System
No, that's not been my experience in any of the locations where I've worked professionally.

Tegus Client
Okay. Do you think that would be valuable to have?

Former System Vice President of Orthopaedic Services at Baptist Health System
I think that would be very valuable to have because the amount of information that the providers need to make their decision is immense. And if you had a mechanism for saying, okay, this patient had XY procedure, this implant used. Back in the day, that would be extremely helpful because a lot of times, the doctors will know I had knee surgery back eight, 10 years ago, but that's really all that they get.

They don't really send off on medical records because those are only kept for three years, and they're sent offsite storage. Today's medical record systems help that, but there's so much that the providers don't know going into a procedure that they wish they would have in my opinion.

Tegus Client
Okay. And I guess the systems that you have brought into place, do they do anything to actually reduce the administrative burden? Or are they just creating more metrics and analytical dashboards that you can use to be prepared to better manage the total cost of care? Are they also doing something to facilitate, like submitting for claims, editing claims?

Former System Vice President of Orthopaedic Services at Baptist Health System
No. It was all about the data awareness, if you will. Just the creation of dashboards and then it was left to the providers to figure it out, say, okay, we're noticing that you're having a higher 90-day readmission. What are you going to do to fix it? There really wasn't that exchange of dialogue to say, hey, this is what we've seen in other areas or here's a medication you can try or using a cocktail instead of Exparel or just whatever it might be. There wasn't a back-and-forth dialogue and I've not had that in any of the locations where I've worked.

Tegus Client
Okay. This was very helpful. Thank you for taking the time to speak with me. I appreciate it.