

Roy Bejarano [0:02 - 0:16]: So I want to welcome everyone to the latest Scale Leadership series. I'm joined by Victor Schmerbek. Victor has been the CEO of Emerus for quite a while now. Over 10 years, is that fair to say?

Victor Schmerbeck [0:16 - 0:25]: No. Since 2019, I've been with the company. I ran our development group for a period of time, but since summer of 19 I've been.

Roy Bejarano [0:25 - 0:26]: So six years.

Victor Schmerbeck [0:26 - 0:30]: Yep. Doesn't feel that long.

Roy Bejarano [0:30 - 0:43]: Yeah, it goes by quickly. It really does. So excited to speak to you about Emerus, but before we get into Emirates, why don't we start as we always do with our CEOs which is how did you end up being the CEO of Emerus? What was the journey like?

Victor Schmerbeck [0:43 - 1:39]: It's a great question. So the predominance of my first, probably two Dec, you know, two decades was on the investment banking and investing sides and for the latter part of that, all healthcare services focused. Ameris had actually been a client when they did their first transaction with a, with a growth equity firm. And then when we did a transaction with our current sponsor, Welsh Carson, I had come in to lead development and help grow the business and then ultimately stepped in, as we discussed, into the president and CEO role. I love what we do as a business. I actually love the notion of kind of leading people and strategy. So in many ways I wish I had gotten there earlier in my career. It's been a fun journey.

Roy Bejarano [1:40 - 1:53]: So you joined Emirates. Why? Why Emirates? What motivated you? What attracted you to that asset? And maybe just describe it. What does it do today? What was it doing at the time? Yeah, a little bit of background on the company.

Victor Schmerbeck [1:53 - 4:43]: Yeah, of course, I half jokingly say, I think Ameris has lived kind of three five to six year lives. Business was founded in 2006 by a handful of physicians really just looking for a better care delivery setting for both patients and themselves and staff. Right. And so it was a relatively small company at the time. They were focused on emergency services solely, but really developed a workflow methodology and care delivery model that resonated with patients and families. It also resonated for employees and physicians. And that was the pretty simple goal in the beginning. The early 2012, they made a pretty significant strategic shift which was partnering with leading incumbent health systems and focused on doing more from a care delivery standpoint to enable patients to stay in their community when they needed levels of care that were higher than just emergency services and integrating and aligning with large health systems. So, you know, the first partners were Baptist Health System in Texas based company, Baptist Health System in San Antonio, Baylor, Scott and White in Dallas Fort Worth. And then we went through candidly a period of a handful of years as a company. And this predates me to a degree of what does it really mean to be a partner with a big health system? Right. You kind of went from we own and control everything to where you're aligning strategically with a big health system. And how do you really get into that culture of network

management, capacity management and being a partner aligned with an incumbent health system. And then the last period of time, which is more my tenure, certainly a part of the, the middle tenure too was really getting us prioritized into what are we really good at, what are our core competencies. And nothing against many entrepreneurs, physician or otherwise. Oftentimes there's a lot of squirrels running around the table and getting focused on what we really think, where we can add value to payers, we can add value to patients, we can add value to families and add value to our employees and our health system partners. And so we narrowed our list of, of things that we really focused on and then have accelerated our growth in our health system partners. We have 12 health system partners today. You asked about basis of Ameris, but we co own, manage and operate small format hospitals really across the country from Washington state to Pennsylvania and in between.

Roy Bejarano [4:43 - 4:47]: I counted over 40. Do we still call them micro hospitals?

Victor Schmerbeck [4:47 - 5:02]: We, you know, the market for some reason developed a nomenclature of micro hospitals. We don't call any of our facilities micro hospitals. They're, they're typically referenced as neighborhood hospitals. And I think uniquely what we've done is.

Roy Bejarano [5:02 - 5:04]: That is a more pleasant term, isn't it?

Victor Schmerbeck [5:05 - 5:07]: But one of the things I think.

Roy Bejarano [5:07 - 5:09]: Micro hospital, I think almost like a toy. Toy hospital.

Victor Schmerbeck [5:10 - 5:50]: Yeah, exactly. So, and I think it's important to note too that in, in virtually all of our facilities there's co loc, ambulatory and outpatient care settings. So our neighborhood hospital would be on the first floor and happy to get into kind of the construct of that. But the first floor, the second and sometimes even third floor are primary care, you know, pediatrics, women's services, outpatient rehab, you know, PTOT clinics, idtf, outpatient imaging, and then more recently even where our partners are co locating ambulatory surgery centers as well.

Roy Bejarano [5:50 - 5:52]: So you're really creating hubs.

Victor Schmerbeck [5:52 - 6:48]: Correct. We call them kind of community care centers or healthplexes. But when I think about our strategic goal when we go into access points that support our health system partner strategy is we want to be able to care for 90 plus percent of that community's needs. If they need a high end oncological, neurological, you know, some other cardiac, you know, intensity, we're unified on emr, be it EPIC or Cerner, it's a direct admission. You know, that patient knows they're going to see Dr. Jones in room 806 and all the care records are, you know, are there for that, that patient. But you know, the, the proximate and this is a national average, on average Nationally, patients drive 34 minutes to get to healthcare. In our setting it's less than 10 in every market and in most cases it's six or seven or eight minutes.

Roy Bejarano [6:48 - 6:51]: So you're bringing healthcare to where the patient lives.

Victor Schmerbeck [6:51 - 6:52]: Correct.

Roy Bejarano [6:52 - 7:05]: Easing access probably resulting in more care, better care, better outcomes, better health, making communities happy. The 40 plus neighborhood hospitals that you have, are they all hubs the way that you're describing?

Victor Schmerbeck [7:05 - 7:09]: For the majority there's, there's a few that are not, but the vast majority.

Roy Bejarano [7:09 - 7:46]: And are they all. So the anchor is predominantly Emirates, starting with the first floor. This is what we're doing. And then the word gets out to other provider groups. Why don't you join us in this construct? We're going to need an orthopedic group, we're going to need a primary care group. And by the way, we've partnered with Baptist or Baylor and we anticipate the health system is going to be an eager partner to you, Mr. Mrs. Orthopedic Group on the fourth floor. As long as you recognize the need to coalesce around a single EMR and share data.

Victor Schmerbeck [7:46 - 8:12]: Does that the only thing I would, we pre program the building in advance. Right. So, and, and one, you made it. You said Ameris is on the first floor. You're never going to see a Marist on any of our buildings. Right. In Dallas, Fort Worth every facility is Baylor, Scott and White. In Las Vegas, every building is Dignity Health. Right. In Pittsburgh, every building is Allegheny Health Network, Wellspan, Christiana Care.

Roy Bejarano [8:12 - 8:15]: Essentially strictly a white label service.

Victor Schmerbeck [8:15 - 8:31]: Correct. And we pre program with our health system partner the second and or third floor in advance. So when we open the hospital, the, the second floor, the third floor is opening maybe not exactly the same time but within a matter of months, you know, a few months.

Roy Bejarano [8:32 - 8:37]: Are these employed groups from the system? Are these affiliates in the system either.

Victor Schmerbeck [8:37 - 8:40]: Either employed or strongly affiliated?

Roy Bejarano [8:40 - 8:44]: Strongly affiliated. So it start, it feels like a Baylor building.

Victor Schmerbeck [8:44 - 8:46]: It's completely a Baylor, Scott and White building.

Roy Bejarano [8:47 - 9:08]: Got it, got it, got it. Okay. And so from the health systems perspective, how much capital are they being asked for to fund and maintain that building. Are

they on the lease? Are they in the capex the build out? So we go the first floor with their registration. How are they looking at it in terms of spend?

Victor Schmerbeck [9:09 - 9:26]: Yeah, so we create a separate business entity that we co own together. It's typically owned 51% by the health system partner, 49% by Ameris, and we deploy capital on a pro rat data basis to that ownership structure.

Roy Bejarano [9:26 - 9:28]: So they've at least got a half partner in you.

Victor Schmerbeck [9:28 - 9:45]: Correct. And so you know, if you think about why does someone, why does the health system partner with someone like us? I would start with speed to market execution in terms of we're really. Well, I'm biased, but I believe we're very good at operating small format facilities.

Roy Bejarano [9:45 - 9:47]: At a minimum. You're focused.

Victor Schmerbeck [9:47 - 9:48]: We're very, very focused.

Roy Bejarano [9:48 - 9:51]: You're not doing that within the system plus 10 other projects.

Victor Schmerbeck [9:51 - 10:22]: Correct. And so we have a very focused, dedicated kind of soup to nuts team from site selection, development, programming of second and third floor, who we need to hire and why, how we cross train people inside the buildings, the type of physicians, the workflow elements inside the building. And we're very focused on driving efficiency for both patients and families as well as a great work environment for our employees and physicians.

Roy Bejarano [10:23 - 10:30]: So is your partnership, the 5149 extends all the way through the entire building.

Victor Schmerbeck [10:30 - 11:53]: And so it does not. It does not. So to be clear, it only extends to the neighborhood hospital and then on the primary care, you know, be it rehab clinics, women's services, pediatrics, what have you. And I think it's important to note too that when you're looking at the submarkets, I don't know how well, you know, I'm in Dallas today, but you know, Dallas, Fort Worth, most people listening to this probably never heard of the communities we're in. In Murphy, Texas, Rockwall, Texas, you know, Grand Prairie, Burleson, Mansfield, Keller, Colleyville. Those are all kind of suburbs and each one of them uniquely has a different population mix. So if it's a, if it's an older community where it's more tends to be more either retirement or Medicare, you know, or later stage commercial from an age perspective, you're going to program the second floor differently, right. You're going to have a different suite of specialists. You're typically going to, you're going to look more at, you know, having rehab and imaging things that that community needs more. If you flip the script and you go to it's a young family suburb Then you're going to typically have OB and pediatrics and women's services. So you're really tailoring the offering to the community a 15 minute drive time, a 20 minute drive

time kind of orientation. But that ultimately is our partner bringing their physicians, their rehab, what the, whatever service it may be.

Roy Bejarano [11:54 - 11:58]: Victor, are they bringing their patients too or is that left on your plate?

Victor Schmerbeck [11:58 - 12:29]: No, no, no, no. They. And the, and the beauty of. Look, not everybody needs to be in a neighborhood hospital for an acute episodic event or you know, an observation or inpatient stay. But people go to their primary care, their pediatric office or for rehab, what have you, all the time. So it creates an opportunity for that hub, as you said, or Helpplex, you know, to be active on a daily basis. And they're not having to go downtown and park in a six story parking garage.

Roy Bejarano [12:29 - 12:43]: And the main source of patients for the second, third, fourth floor. You're on the first floor. Your retail, you're visible. You're almost like an urgent care center is visible exactly like an urgent care center, but with, with more services offered.

Victor Schmerbeck [12:43 - 12:46]: A much higher degree of, of service.

Roy Bejarano [12:46 - 12:56]: You really as almost like a, a retail concept. They view you as the anchor tenant drawing in patients that then flow through into the rest of the building. Yeah, yeah.

Victor Schmerbeck [12:56 - 13:51]: So if you to that point, when you think about if, you know, again going down the path of Baylor, just because we're on that one, but it agnostic to health system, they can put a primary care group and a suite of specialists that either rotate that or maybe they're, you know, two or three days a week or, or maybe there every day of the week. There are many people that come into our facilities that do not have a medical home, unfortunately. Right. So our ability to at post discharge identify that patient to a primary care physician in the same location that they can, they can create a medical home with or a pediatrician, what, what have you allows the health system to, to get the benefit of growing that panel more quickly than maybe if they just were isolated in an mob away from, you know, a larger health care destination point.

Roy Bejarano [13:51 - 15:00]: And so are you getting patient referrals from urgent care centers who have tapped out in terms of their abilities? Yeah. So it begs the question, at least from my mind's perspective, as you sit and you look out at the thousands of urgent care locations across the country. I don't know if it's tens of thousands, but I wouldn't be surprised if we're getting there a lot. Yeah. Why aren't there tens of thousands of community Hospitals, neighborhood hospitals, the way that you define them, with deeper, really urgent care capabilities, er, capabilities that are more capable of responding to a broader suite of patient needs that's highly efficient, that then flows in on behalf of the health system's benefits into these other specialists. You think that the model, the model, not just conceptually, but practically at Emyris makes perfect sense. It's almost like I'm listening to a CEO who's running a great orthopedic MSO, and yet where are the other 500 orthopedic MSOs? Why isn't this more established?

Victor Schmerbeck [15:00 - 16:00]: I think there's a continuum of care and we don't have a script here, but if you think of just a triangle from a pyramid standpoint, and I'm going to the acuity of the patient, right. And at the top end of that, the peak of that, we should have the fewest facilities that we have, which those are the tertiary and quaternary facilities. And they should be, in our opinion, a very high center of excellence. And I think what we're seeing with many of our health system partners is they're beginning to rationalize services based on the size and scope of their facilities. So instead of trying to put every service line in 20 hospitals around Dallas Fort Worth, you're creating hubs of excellence around cardiac, onchaological, neurological, disintermediation. So that at the top end, the fewest number of facilities, in my opinion, that we have across the country, and you're seeing that.

Roy Bejarano [16:00 - 16:07]: You're seeing the number of hospitals that's gone from 8 to 10,000 down to 4 to 5,000 over the last 40 years.

Victor Schmerbeck [16:08 - 16:14]: Right. As you slide down the acuity scale. Right. And going from top to bottom, the.

Roy Bejarano [16:14 - 16:16]: Bottom is, the bottom has to fill.

Victor Schmerbeck [16:16 - 17:02]: Out, the bottom has to fill out. And those tend to be physician clinics, urgent care, things of that nature. I think we fit in the middle of that. Right. We're a piece of the puzzle. We're not the sole solution. And there's a ton, as we've seen with, you know, on the surgery side and even on general inpatient care, there's a ton that is going from the top end of that and sliding down because you can, I mean, our length of stay. Same. And this is actually payer data that I'm quoting here. We get it from our partners too. But the same risk adjusted patient has a length of stay in our facility that's almost half of what it would be in a big box hospital.

Roy Bejarano [17:03 - 17:07]: Is it fair to call what you're doing predominantly Outpatient er?

Victor Schmerbeck [17:08 - 17:26]: No. Well, we do have observation care, but we take care of people that need to be in the hospital. I mean it's generally non ICU care. So it'd be step down unit and med surg, you know, general medical services. Some of the, that needs to be in the hospital for, you know, two, two and a half, three days. I mean there are some longer, you.

Roy Bejarano [17:26 - 17:29]: Know, stay patients, patient eon short term stay.

Victor Schmerbeck [17:29 - 17:34]: Correct. And that general patient is spending four plus days.

Roy Bejarano [17:34 - 17:35]: Yeah.

Victor Schmerbeck [17:35 - 17:56]: Big hospital and the cost. So three things I would point out materially, shorter length of stay, 40 plus percent, lower total cost to the payer on the order of

20% and lower readmission rates. So national average on readmission is 10 plus percent. We sit at 1.2%.

Roy Bejarano [17:56 - 18:17]: Let me get back to that in a second because I have no doubt that you offer a lot of efficiency gain based on your focus. But let me just ask at a macro level, how many of these neighborhood micro outpatient ER plus short term stay. So that's sort of the terminology, the box. How many of them are there in total across the country?

Victor Schmerbeck [18:17 - 18:19]: It's about 150.

Roy Bejarano [18:19 - 18:21]: How many should there be?

Victor Schmerbeck [18:21 - 18:22]: And we're a third of it.

Roy Bejarano [18:22 - 18:24]: How many should that be? We had limit.

Victor Schmerbeck [18:24 - 18:26]: I could, I could make an argument.

Roy Bejarano [18:26 - 18:29]: That perfect information and I could make.

Victor Schmerbeck [18:29 - 18:56]: An argument that you should look at every hospital that's 50 to 150 beds that has historically had tried to put everything into a small box, rationalize those campuses, get your high end tertiary quaternary stuff to a center of excellence. And that 100 bed hospital, it's been there for a very long time, could be much more efficient with a 20, 25 treatment room.

Roy Bejarano [18:56 - 19:00]: So we reduce the beds, we reduce the size of that hospital's er.

Victor Schmerbeck [19:01 - 19:49]: I think you'd look at the volume in a given facility. We think about the acute episodic side in kind of pods from an efficiency standpoint. So you kind of look at what's your utilization. Right. So we, we often have this discussion that's interesting, you know, and it's maybe a little cynical in my comment here, but is, you know, you get, you get an ER staff or you get a team in a, you know, 50, 80 bed ER and they're like, well, it's easier for you because you have less rooms, it's more efficient. But then when you look at it and you say but you're turning over your room four times a day. We're turning over our room eight to ten times a day. Right. Just due to the Efficiency. And some of it's not rocket science. Right. If you're in a big health system campus, you know, big medical center, your.

Roy Bejarano [19:49 - 19:53]: Feedback to Mr. And Mrs. Hospital is predominantly, you've overbuilt.

Victor Schmerbeck [19:53 - 20:08]: Well, it's not just that, but. And it makes sense why they do it. Right? You share labor, all this stuff. Right. So it just takes longer. We have dedicated ct, we have dedicated lab. We have, you know, the history of.

Roy Bejarano [20:08 - 20:40]: All business, as I heard one day in this throwaway quip from, I think it was the founder of Intel. But it's one of those, one of those tourisms that's been floating around the west coast forever is the history of all businesses defined by two words, bundle and unbundle. And so the hospitals have been bundling, and you're in the business of helping them with the unbundle because there is such a thing as bundling too much. So that's interesting. Okay, so back to my question. If there are 150 of these today, 200 of them today, how many should there be?

Victor Schmerbeck [20:41 - 20:48]: It's a good. I've never really sat down and looked at what, you know, it's a great question for our team. Maybe one that I follow up on.

Roy Bejarano [20:48 - 21:23]: Yeah, look, we used to think that. Let me give you an example. We used to think that 6,000 ASCs was a good number. And we used to show up at the becca Conference for ASCs 15 years ago and hear that, you know, painfully, we've reached the peak of maturity. And everyone used to look around and frown their heads and go, oh, God, no more growth in the ASE space. And I always found that view to be a little, a little bit of crowd think. It didn't quite resonate with me. I'm always a little bit skeptical of crowd think as you know. And lo and behold, it could be.

Victor Schmerbeck [21:23 - 21:25]: Three to five times it is today.

Roy Bejarano [21:25 - 21:27]: Years later, there are 10,000 ASCs in America.

Victor Schmerbeck [21:27 - 22:34]: There's no doubt in my mind that I mean or on a path. And Roy, you and I talked about this to some degree. You know, as we've evolved and we're now in, you know, have 12 different partnerships. And the evolution of each one of these is typically, you know, you start with three or four facilities as a first phase. Right. We started in San Antonio, our most mature market. We started with three facilities. Today we have nine, and we're opening our 10th in 2025. We started with Baylor, Scott and White with five facilities. We're now at eight. We're adding more. Right. So in Las Vegas, we Started with four just prior to Covid, so it delayed some of the maturation process. But we're opening a fifth this year, we'll open a six next year, and we're looking at number seven. So the embedded growth inside of our existing partnerships, which I think also goes to the health system, is seeing value in what this provides to their overall network.

Roy Bejarano [22:34 - 22:59]: Because some of those patients. Not because. But in addition to all of those patients flowing through that building, that location that you've created, whether it's the first floor or the eighth floor, I would imagine a good number of those patients find their way back to the health system as well, where the health system is 100% owner and happy to receive them. Is that fair?

Victor Schmerbeck [22:59 - 23:46]: No, very fair. We opened a partnership with Allegheny Health, Allegheny Health Network, which is actually owned by Highmark Health, the very large

Blue Cross Blue Shield provider in Western Pennsylvania. So it's Pittsburgh. And that surrounding msa, the dominant provider for a very long time in that market's been upmc, University of Pittsburgh Medical Center. So if you look at the first. Call it 18 months of data that we had, and we opened these in. We opened the first one in February of 2020, and then we opened in March, May and August. So we have four facilities there. Interesting time to open. I'm told we were the first virtually accredited facility by Medicare ever. I don't know. Never validated. I don't care.

Roy Bejarano [23:46 - 23:54]: That's. Did they. Did they get a tour on camera? That's funny.

Victor Schmerbeck [23:54 - 24:46]: Now, they came back and obviously did a physical here, but. But nonetheless, the point I was making is on the order of 25 to 30% of the patients that presented at our neighborhood hospitals over the first year was the first time that patient had ever touched Allegheny Health Network. And then you think about the reattribution rate to your point, back to either their primary care, a GI specialist, you know, a specialist of sorts, or, you know, if they needed a higher level of care to the hospital, was a very high percentage. So if you think about network capture for the system, there's a huge benefit of getting into the communities where you can provide services instead of telling patients and families, we're going to pop ourselves in downtown, and you come to us.

Roy Bejarano [24:46 - 27:05]: Yeah, I think we went through a mind shift in health care in hospitals. So I want to get closer and closer to it because I actually think these hospitals are coming to my world where I live, where I grew up. And your world, where you live, you grew up, which is all performance. And just like I have a nervousness sort of an instinctual reaction to crowd think. Not that I'm not guilty of it too. I'm guilty of everything that everyone else is guilty of, but at least I have a sense for it that causes a reaction. I also have a sense for bloat and excess investment that causes a reaction. And I think the hospitals went through a paradigm shift where 50 years of incessant spend measured carefully. You can see the inflation rate, you can see the percentage of GDP results in a heavy focus on assets. Big campuses, big brands, big locations, prime locations. Downtown, Downtown, downtown. And I feel like these hospitals, it's so healthy in partnering with you are really representing where their mind is at today. And it is a shift far more focused on performance. Small, local, easy patient experience. Right. First, second, third floor. Speed. Speed, right. A word that was never associated with large hospitals. A cost. So I think it's a really interesting time and I love it. Just like the surgery center space has benefited from the same hospital. Not just participation, hospital leadership. Now at 6,000 AACs, it was hospital participation. All of this. All those 6,000 ACs were really managed by other groups. But at 10,000 ASCs, there's a lot of hospital leadership there as well. And I think your space will probably over time see more hospital leadership just as much as there is hospital partnership. But I want to talk about, want to talk about reimbursements because I'm curious, hospitals are still being pointed at as an anti force, a counterforce to value based care, performance based reimbursement. How does that reconcile with all this successful inherent coordination that's going on in your locations between the first floor, the eighth floor and the hospital partner or parent, how does that translate to coordinated care from a reimbursement standpoint?

Victor Schmerbeck [27:06 - 27:19]: So I think in our world, and we spend a lot of time with people like Highmark, who's a partner of ours, I think they're the, I don't know, third or fourth largest Blue Cross provider in the country. We spend time with other payers as well.

Roy Bejarano [27:19 - 27:21]: Do you spend time with Kaiser at all?

Victor Schmerbeck [27:22 - 27:34]: We're not in a market where Kaiser really is. And so I mean we, we have dialogue with them, but it's not, you know, we're not embedded in, in a market. We've been in markets where they've tried to come in and do something, but.

Roy Bejarano [27:34 - 27:39]: Yeah, they recently entered Pennsylvania. So it's going to be interesting to see what, yeah, they.

Victor Schmerbeck [27:39 - 27:59]: And look, not. We don't need to get off on Kaiser. You know, I mean they have a very unique Model where they dominate and where they own all the, you know, they own the physicians, they own that, the hard assets, they own the health plan. I think time would, I think history would tell you they've had a harder time going just with the health plan into a market without being able to.

Roy Bejarano [27:59 - 28:03]: Bring very different, very different when you're one of many, right.

Victor Schmerbeck [28:03 - 29:51]: But on the coordination of care, we really think about it from the entire episode of care. So when we sit down with a Highmark, for example, and we look at coordination of care, the neighborhood hospital is typically a piece of the puzzle, right? So the question is, is that patient being readmitted? Do they go to a higher level of care? Do they need follow up? And more importantly, are we getting them to the best value and quality from a follow up standpoint? And so that's where being integrated on the EMR really being coordinated with your partner and the payer partners on, hey, if I'm in, you know, we're in Westmoreland county in the Hempfield area, which is kind of south of, of Pittsburgh. And in that location we have our neighborhood hospital. HN has a cancer center. We've got a suite of Mob. We've got 60,000 square feet of health care in that facility. But uniquely looking at, okay, if I have a GI issue and someone at discharge needs to follow up, we have a notion in our EMR where it says, and it may be someone that's part of a shared savings program with Highmark. Right. On a value basis. But hey, here's the top three GI groups as it relates, as it relates to cost and quality. So let's get that patient. If they don't have an identified GI specialist physician, how do we get them to that group, one of those groups, and we schedule that appointment at discharge. It's not, you need to follow up with a GI doctor in the next week. It is, you know, we're looking at the schedule of Dr. Jones and he or she is available on Tuesday at, you know, nine.

Roy Bejarano [29:54 - 30:18]: So that's, so it's interesting you're playing this, in this nexus role where you're, you're at a point of inflection where a procedure leads to a follow on referral, you know, acute post acute, pre acute. So you, you are almost like a train station, the way that a primary care group can be a train station. But it's, you're really focused on episodic acute care versus primary care versus primary.

Victor Schmerbeck [30:18 - 30:48]: Care, where we're going to see patients that are sicker. Yeah, no, the, the 90 plus percent of our patients are, you know, in the, in the, in the acute episodic world, you know, the higher the number on a leverage level code, the, the more, the more acute they are. The vast majority of our patients are level four and five. Right. Three, four and five. We don't see low end patients for the most part. And frankly when we do see them, they tend to be Medicaid because they don't have another option.

Roy Bejarano [30:48 - 31:31]: Yeah, all right, so that's another challenge. So per member per month is not an option for you. Wellness visits, not an option for you. You are squarely focused on the ER plus days, but nevertheless you are driving performance, generating savings, reducing readmission rates. So all that benefit is flowing to the system. And your point to me is. Hey, Roy, for whatever clinicians, specialty groups, primary care groups are enrolled in value based care programs who are sharing in those savings as a result of my actions, they're getting a bonus payment, a savings payment. They're getting higher star ratings, higher per member.

Victor Schmerbeck [31:31 - 31:31]: By the way.

Roy Bejarano [31:31 - 31:43]: Star ratings is a residual flow into value based care. If the hospital that I'm partnered with or the health system is participating in savings programs, they're benefiting too. I am Emerson.

Victor Schmerbeck [31:44 - 31:46]: So think, think about that. Think about this.

Roy Bejarano [31:46 - 31:54]: We're not necessarily focused on contracting directly with that is that, is that it's fair.

Victor Schmerbeck [31:54 - 32:43]: I would love to find a way to participate, you know, in that. I don't think we've where we found value in, you know, in our world in the sense of, you know, if we can truly, which the data suggests we can lower the total cost on the episodic basis, we can get that patient to the right place post discharge. From a follow up standpoint, where we get the benefit is payers altering member plan design, employer groups really motivating their members to go to our location. So it's not a shared savings model. It's more of we can be more efficient. That's you asked earlier about do we get referrals from urgent care all day. Right. And the proposition we're giving to them is we can take better care of your patient at a lower cost.

Roy Bejarano [32:43 - 32:44]: Right.

Victor Schmerbeck [32:44 - 33:01]: When they need a higher level of care. And so that coordination piece we believe gives us the opportunity to grow same store volume outsized to the market. And so it's, you know, and we're aligned as it relates to our health system partner in that regard.

Roy Bejarano [33:01 - 33:11]: You're looking at value based care programs the way that a successful ASC management company looks at them. I know that I'm part of the solution, but I haven't necessarily been invited to the party yet.

Victor Schmerbeck [33:11 - 33:13]: Correct. That's a very good way to say it.

Roy Bejarano [33:13 - 33:59]: I want to share this podcast with my payer team and I want to share this podcast with the former president of Sound Physicians who's a member of Gold as well. So he'll join us shortly when we, when we head out and hopefully you'll come to that too because I think about maybe Sound Physicians as, as an interesting comparable in that they were focused, they still are on ER management within health systems across the country, but also expended extended their reach into the catchment area, the affiliate groups in driving coordinated care on behalf of health systems as well. And I think, if I'm not mistaken, I never worked there, but they ended up participating with health system support in a lot of performance based reimbursement programs. So I think that will be an interesting conversation as well.

Victor Schmerbeck [33:59 - 34:04]: It's certainly an opportunity that we have our eyes on. I don't have the answer today.

Roy Bejarano [34:05 - 35:33]: Yeah, look, it's all good, it's all good. Obviously the value that you're creating is recognized and leading to more growth and leading to more savings. So it's not like coordinated care isn't working. And this is a thesis that my partner Jason and I have been driving home across the industry for as long as possible, which is there's many different ways to coordinate care and they don't all have to flow through cmmi. Right. So that's interesting. So two themes that I really want to dive into before we finish up that are very near and dear to my heart, that we come back to again and again. And you are squarely in the heart of both of them. One is private equity in health care and the other is MSO hospital health system partnerships. And I actually think the two are very related. The point that I make to the private equity community whenever I can, all of them is the number one value generator that they have created for health care in America is creating MSOs. Because without MSOs there would be no MSO hospital partnership. It would just be hospital, hospital and practice, which is what the world that you and I grew up in in healthcare, hospitals and practices, and no third option. But as soon as private equity helped fund a lot of these MSOs to scale, suddenly hospitals had large bulky companies, teams, credibility, history, marketing, capital, partners that they could reach out to and say, I've got a challenge here and I don't quite, I don't have what I need to solve it on my own. Can you help?

Victor Schmerbeck [35:33 - 35:35]: Fair, Fair. Very fair.

Roy Bejarano [35:35 - 35:38]: So let's delve into the second one hospital partnership.

Victor Schmerbeck [35:38 - 36:02]: And I would, and I would say, look, if you go back and you were in San Francisco for the J.P. morgan Conference and you can read Becker's or Modern Healthcare all their recap notes, it doesn't really matter. The three primary themes were, at least

from big health systems, right was move to outpatient. We know we need to partner and we need to figure out how to capacity manage our facilities.

Roy Bejarano [36:03 - 36:05]: And they're right on all three to.

Victor Schmerbeck [36:05 - 36:33]: Get, get the patient to the right place for the right reason at the right cost. In a lot of cases that means, and it's hard, but if I go talk to the chief financial officer, CEO of all of our health system partners, they're highly aware that they have 20 plus percent of their patients that are margin dilutive, staying too long in their building, creating backlog of getting patients that really need to be there into a bed. And they're trying to figure out a solution.

Roy Bejarano [36:35 - 36:58]: Are you okay? I'm going to stay on, I'm going to stay on tone because I have so many questions. All right, so back to the hospital partnership question. What are the ingredients that you look for that are musts and what are the yellow flags that raise suspicion that this might not work and what are the red flags that you walk away from? What have you learned in all.

Victor Schmerbeck [36:59 - 37:54]: That's actually a really great question. Look, the very first and I think the foundational is we have to have strategic alignment, right with our, with our health system partner. And I think we feel like, you know, we need to be, I mean we're creating a marriage. It's not a, you know, negotiate a prenup just in case. But you know, it, it is a marriage and we're going to be embedded. I mean every one of our, every one of our market CEOs sit on, sits on, you know, the CEO, council president, council of the big health system. I mean we are fully integrated. So that alignment, we're looking for strong brands and strong markets. I think those are probably easy. You know, you can, you can do your, you can do your calculus with data analytics on markets and, and who you want to partner with. But the strategic alignment is really the core of it.

Roy Bejarano [37:54 - 38:02]: I want to go back to that. I just want to understand, unpack what you said. Your, you call them CEOs are sitting on health system boards.

Victor Schmerbeck [38:03 - 38:19]: Not on the board, but like if take Baylor, Scott and White, they have, or Baptist Health System, right. The, the leader of that market overall for Baptist Cell System has A typically would have like a president's counselor, CEO council or operations council and it would.

Roy Bejarano [38:19 - 38:23]: Be, you know, hospital cos would join.

Victor Schmerbeck [38:24 - 38:24]: Correct.

Roy Bejarano [38:24 - 38:26]: Every month? Every quarter.

Victor Schmerbeck [38:26 - 38:31]: Oh no, these are off. I mean in some cases they're weekly, but certainly monthly.

Roy Bejarano [38:31 - 38:42]: Your representative for that region for that location is joining their hospital CEOs in that CEO Council on as much as a weekly basis in perpetuity.

Victor Schmerbeck [38:42 - 38:43]: And perpetuity.

Roy Bejarano [38:43 - 38:44]: So it feels like.

Victor Schmerbeck [38:44 - 38:45]: And it goes down the list you.

Roy Bejarano [38:45 - 38:47]: Go, you're deeply embedded.

Victor Schmerbeck [38:47 - 38:58]: Yeah, same with our cna, our chief nursing officers as it relates to quality infection control, environment of care. You know, same, same premise.

Roy Bejarano [38:59 - 39:10]: And they probably have a technology department and you're probably meeting there as well. And so you sprinkle out your org chart and there's a counterparty at the health system for every one of those org chart department heads.

Victor Schmerbeck [39:10 - 39:55]: And then, and then below that, Roy, when you think about, you know, not every one of our neighborhood hospitals, the submarket community is going to refer or deal with every hospital of our partner. So they tend to have a sister facility. Right. That they're closest to. They go to their go to. Right. And the big health system is actually referring patients to us and we're referring patients to them. And so at below the CEO, C and O level, our hospital administrator and you know, the, the administrative team at that hospital have their own, you know, kind of cadence of how they work together.

Roy Bejarano [39:55 - 40:22]: So one of your global master questions, overriding questions, is how deep will we be able to integrate with this group? Because, Lord, I know a lot of integration is going to be required and if you're getting pushback along the way. So now we get into the yellow flags and the red flags. So Yellow flags is not interested in speaking to you. Their nursing team is very difficult to work with. They don't communicate well. So these are the beginnings of yellow flags, red flags. So walk me through. What do you look for?

Victor Schmerbeck [40:22 - 41:23]: Yeah. So it's interesting that one of the things that we've done and I, and I, and I'm going to say this and I mean it deeply because I really don't mean it to sound like it's arrogant, but when we begin a discussion with the new health system, one of the things that we've put down as a criteria is we want their clinical leadership team to come into one of our markets and see our facilities and we want them to do that within a defined period of time. Right. That's reasonable. And what we found is when we get them into our facility and they get to see Talk to physicians, talk to clinicians, talk to our leadership team. And they see kind of what we do. It accelerates our opportunity. And sometimes it may be a no. Right, but it's a

quicker no, if that makes sense, if it doesn't make sense to them. But more times than not, it accelerates our discussion and it gets you into the discussion of do you find yellow flags? Do you find red flags? Right?

Roy Bejarano [41:23 - 41:28]: You invite, you invite them over and you're interviewing them as much as they're interviewing you.

Victor Schmerbeck [41:28 - 42:14]: And it's. And oftentimes there's what we refer to as scope creep, right? You get a team in there and they're like, well, but this community is growing. There's 10,000 new housing permits, there's no houses yet, but we want to be the first one here. Or it's well, but we need to have these seven other service lines that you can't put in a small format facility. It doesn't economically or practically make sense. So you start to flesh out, you know, what are they, what are they really? I don't mean this disrespectfully to anybody, but what are they trying to accomplish? Are they, are they really trying? They want a hundred bed hospital, but they're trying, but their CFOs saying you can only get something smaller or are they really aligned around. This is great care delivery and benefits our system.

Roy Bejarano [42:14 - 42:17]: Are you there for these conversations based on your experience?

Victor Schmerbeck [42:17 - 43:18]: It depends. Typically not the first go round. I mean, our operations team and development team and physician leadership team will be there. But I always have a dialogue directly with the CEO in every one of our cases. And I'm a huge believer in relationship capital and investing that time. There's no doubt we're going to have issues that come up in any one of our partnerships. Right. But being open and transparent, being able to talk about it, we'll get to resolution more quickly. And so, you know, you could pick any one of our partners. I mean, I talk to the CEOs quarterly, you know, just understand strategically what he or she is thinking, you know, what we're doing, how are our teams working together? And I'm a big believer in let's not let something fester. If you're hearing from your team that we're not doing something that you need, you know, first line of defense is go to our CEO, you know, go to our team, but don't ever hesitate to call me and say, hey, we have an issue.

Roy Bejarano [43:18 - 43:32]: Do we need parameters on what upper, lower thresholds are for timeline as well? Like you're gonna be patient, empathetic. Hospitals have a lot of stuff going on, but you're not going to spend 15 years to find out whether.

Victor Schmerbeck [43:32 - 43:48]: Oh, I mean, look, and that's where I went back to the arrogant statement. We, we have a defined period of time. I won't say it, but it's a, you know, it's within a short number of months. If, if a health system's not willing to commit to come spend time and see the facility, we'll oftentimes go pencils down and just say, let's, you know.

Roy Bejarano [43:49 - 43:50]: That'S a good test.

Victor Schmerbeck [43:50 - 44:10]: Fully, fully appreciate that you have a lot of other things going on when you're, you know, when we're ready to do this together, let's go do it. But

otherwise a commitment test, opportunity, opportunity cost, you know, and it sounds crummy and I don't mean for it to sound crummy, it's just, it's a discipline that we've tried to instill.

Roy Bejarano [44:10 - 44:37]: Your crummy spider senses are too finely tuned. I would down notch them one bit. Doesn't sound crummy at all. It sounds very reasonable. All right. In the minutes that we have left, private equity, you've had a partner all this time. One of the most well respected brands in the space. Welsh Carson can't really do much better than Welsh. Other than singing their praises, what role have they really played over the years? What, what would this business be without Welsh?

Victor Schmerbeck [44:37 - 46:57]: Good question. They've been a great partner, they've been very patient. They have allowed us to really focus on what we believe matters. They challenge us often on. I was actually having this conversation earlier this morning with, with one of the Welsh guys is we, we've, and I talked about it earlier, have been very focused on core competencies. We have three strategic priorities today and they've been the same for four years. And so oftentimes at board meetings, particularly around budget and annual strategic planning, there's what can we do over here? Or what can we do over here? And they've allowed us to really. My, my comment to them has been we've had a ton of success with our three. We still think there's a ton of white space on the three, the strategic priorities. If you want us to add a fourth, we work for you, I get it to a degree or work for the board, but you're gonna have to take something off our plate. And the, and the answer typically is come back to keep doing what you're doing. Where I think they add a ton of value. And Welsh is not the only one that does this. But Welsh is heavily invested in a resource group where we have experts that we can lean on with managed care contracting with business continuity and cybersecurity, with people experience in hr, where we can benchmark ourselves against the portfolio and others. On the, on the business continuity and cybersecurity side, it's probably three or four years ago in a. In one of our CEO forums is we all said, look, we're spending a ton of time trying to get our arms around this, a ton of time and money. And so we brought it. They brought in an enterprise solution where the entire healthcare portfolio went through the same process of assessing where do you sit on the continuum, you know, how much are you spending relative to effectiveness? And so it gave you a comparative set on a common set of themes that really allowed us to accelerate our progress. But I would say, generally speaking, I mean, a lot more of what I would call kind of first tier private equity groups have invested in resource groups that can benefit their portfolio with expertise on procurement, managed care. It, you know, you name it. Where you're not necessarily out on an island trying to solve every issue on your own, you get the benefit of the collective.

Roy Bejarano [46:57 - 47:05]: I think that's, that's great insight and I would imagine it's extremely valuable. Victor, I want to thank you for your time. I hope you had fun.

Victor Schmerbeck [47:05 - 47:09]: I did. It was good. All right, See you.

Roy Bejarano [47:09 - 47:10]: Take care, my friend.