ASCEND MEDICAL

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Evolving with the Times – Understanding & Planning for Virtual & Mobile Care

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Key Takeaways

Setting the Stage: A confluence of market dynamics are driving an expansion of traditional healthcare site-of-service scope to include now integrated virtual and mobile care offerings.

Reimbursement

- The change in reimbursement from CMS around the hospital for the home area is having an enormous impact on our industry.
- It is estimated that $285 billion worth of Medicare spending is going to be shifted to home-eligible services by 2025.

Employer Healthcare Spend

- Employers are confronting material increases in healthcare spending. As a result, deflationary service delivery models are being explored.

COVID

- We saw 15-20 years' worth of change in the adoption of telemedicine - there were newly formed opportunities in patient access.

Care Delivery Efficiency & Reach

- CMS has been relatively disappointed in what traditional care models have been able to accomplish with harder to reach patients in terms of increasing utilization, improving healthcare access and outcomes, and lowering costs.
- In an integrated virtual and mobile care model pilot, 80% of the "unreachables" in a particular patient pool were able to have necessary patient visits. That type of result driven by integrated virtual and mobile care models is appealing to CMS and other payers.

Innovation

- New technologies and innovative care models have become available, expanding the realm of the possible. Technological innovation enabling home dialysis, for example, has been transformative for patients with renal failure.

Where Is the Market Going?

Primary Care

- Within primary care, expect to see the emergence of "advanced primary care," with an expanded scope of care and more integrated clinical services. For example, brick-and-mortar primary care integrated with, for example, virtual behavioral health, wellness, weight loss, preventative, anti-aging and sexual health services.
- Services with a stigma were the earliest to gain traction with virtual care. With technology improvements and virtual and mobile care market maturation, expect to see these care delivery channels proliferate to more use cases.
- Innovators focusing on just one care or condition type – for example, sexual health – present some risk of cutting into patient bases of traditional primary care practices. That being said, if traditional brick-and-mortar practices are able to integrate a suite of virtual and mobile care offerings into their service portfolio, the integrated model that combines sexual health with holistic primary care will present distinct competitive advantages over pure-play alternatives that focus on just sexual health.

Specialty Care

Virtual and mobile care is not limited to primary care – rather, its application has the potential to be universal across specialty care. Representative example specialty care use cases referenced in the body of the interview across:

- Cardiology
- Endocrinology
- Neurology
- Orthopedics
- Urology

Every specialty should assess its virtual and mobile care business plan. We have to ask these questions because all of these access points have different costs of delivery and, frankly, utilization rates too. It's a complex formula, but ultimately virtual and mobile care increases access and can increase utilization. For your MSO:

- What can be done virtually?
- What must be done in a brick-and-mortar setting?
- What can be done at home or at a patient's place of business?

What Are The Expected Outcomes & Implications?

To the Boarder Healthcare Market

- More Consolidation. Virtual and mobile care are often best delivered when a certain patient volume scale exists. As such, MSOs will continue to see growth synergies through consolidate & scale.
- **"Platformization."** The virtual and mobile care markets have an abundance of innovators and pure-play offerings. A key to adoption will be the ease of integration with traditional care delivery models. Expect to see companies pursue "umbrella offerings" that seek to pull together some of these disparate, fragmented virtual and mobile care service offerings.
- **More Strategic Partnerships:** The demand to offer more services across more sites-of-service is continuing to grow. Not all MSOs will be capable of building out the requisite infrastructure internally. As such, organized B2B collaboration will increasingly be required by certain MSOs to deliver a scope of care that allows that MSO to remain competitive.
- **New Forms of Competition:** Pure-play virtual care offerings will cannibalize a portion of the total addressable market for traditional brick-and-mortar MSOs. Further, with virtual care, all MSOs are empowered to expand their geographic reach.

To Patients

- **Access & Utilization:** Ultimately, patients should benefit from improved access and care plan achievement through virtual and mobile care offerings.
- **Interim Confusion:** In the meantime, patients may face some challenges and confusion around (i) receiving piecemeal care across a fragmented virtual and mobile care market and (ii) certain market innovators that are delivering care offerings outside of traditional healthcare insurance programs.

To Providers

- **Lifestyle Flexibility:** Ultimately, providers can realize lifestyle and flexibility benefits through virtual care. That being said, taking advantage of new care delivery channels will require a material behavioral change, which not be slow to be adopted.
- **Top of Licensure:** Virtual care represents another "tool" to help stratify care delivery and allow providers to practice at the top of their licensure.
- **Income:** Expanded scope of clinical services presents the opportunity for increased income.

To MSOs

- **Investment:** Investment will be required to build out scalable, high quality virtual care programs. MSOs will need to invest in developing supporting business and operational plans, as well as leadership who is equipped to run these virtual care programs.

- **Partnership:** Not all MSOs will be interested in investing to build in-house programs to deliver an ever-expanding scope of services across a growing site-of-service reach. Receptivity to strategic partnerships and operational programs to execute on the same will be required to fill gaps.

To Payers

- **Favorable Outlook on Virtual & Mobile Care:** Payers will continue to appreciate the potential direct & overhead cost efficiency, preventative care benefits, care access improvements, and care plan adherence benefits of virtual and mobile care.
- **Pricing Dynamics:** It will take time for payers to work through appropriate incentives for migrating care to virtual and mobile settings. Further, payers may face challenges arriving at optimal pricing balancing the lower cost of care delivery for virtual and mobile care vs. the investment cost required to build truly effective virtual and mobile care programs.

Background

I'm Jason Madsen, the founder and CEO of Ascend. My background is in commercial real estate, where I spent most of my career. Through my experience in real estate, I had this unique position where I would see whether healthcare, retail services, banking, finance were succeeding. And in the mid-2000s, our leasing team approached me about our retail portfolio in the Intermountain West regarding emergency room doctors who want to open urgent care centers. So, we started digging into what urgent care is, what the opportunity was. Through that, I co-founded Well Street Urgent Care. We raised a $75 million commitment from FFL Partners out of San Francisco, and we now have over 100 locations serving patients in four states, soon to be five. And, we have powerful health system partnerships that help us with our rates and help us with patient access and conversion. I stepped down from the senior management team a few years ago and was thinking about where I would be called next to help with the challenges we're facing in U.S. healthcare. The urgent care business works so well because primary care is broken, there are justc such restrictions and strictures in the access pipeline. What we decided to focus on at Ascend was to bring some retail concepts into the primary care space. I did a seed round that my wife and I put in, and then we raised a Series A to get us launched in Atlanta. I raised that money to go into more of a retail primary care concept in the fourth quarter of 2019, just before COVID-19. We saw 15 years or maybe 20 years worth of change in the adoption of telemedicine and the whole landscape changed across consumers, providers, health systems and payers - there were newly formed opportunities in patient access. And so, we pivoted into a virtual care model with a mobile component to take care of all the in-person needs. We've now done the old Field of Dreams, "If you build it, they will come." We are now starting to attract talent virtuosos like Tom Bowen Wright and others who are able to come in and help take this vision and this hunch and put some real structure behind it to help us with advanced primary care with integrated behavioral health, with wellness, prevention, anti-aging, sexual health - all of this tied in for the whole family, from sunrise to sunset of life.

Tom Bowen Wright here. I was involved with a digital health startup in my 20s, but about ten years ago, I found myself as a healthcare consultant for McKinsey helping CMS with the early structures of Obamacare. I had one client who had gone really long in the patient-centered medical home space, and that was something that I obviously really gravitated to. I really bought into this idea of value and spent the last ten years in big health systems such as Baylor Scott & White in Texas, and then with Optum in technology, digital leadership, and then transformational leadership. My focus was on thinking about how you transform the delivery system to meet the needs of the population. Here we are, ten years on, and really just reflecting on that promise of a patient-centered medical home. At the time, everybody bought into this idea of your primary care office not just being somewhere where you could get treated for being sick but really being at the forefront in the battle for prevention and disease management. And yes, we've made some progress - you think around cardiac care and some of those outcomes. But, there are still big areas where, quite frankly, the traditional primary care office is not meeting that vision of that patient-centered medical home, especially in areas like behavioral health. Having been in the system, I really understood the challenges to realizing that vision - many of them are economic, many of them are operational. There was a real opportunity to create something outside of the core health system and solve these problems in a way where you can partner with traditional healthcare and achieve elevated levels of access, quality, and affordability. I found Jason with a similar vision and passion and joined Ascend a few months ago.

Interview

You used the word virtual care. There are lots of concepts in and around that overarching theme that practices have partially implemented - chronic care management, remote patient monitoring, care management, care coordination, telehealth. As a foundational starting point, can you walk us through the ecosystem of what is included in the full scope of what you define as virtual or remote care? How does the market break down?

I agree with you. It is an inclusive term. What we're finding is that every three months, there are new areas and new opportunities. There is a lot of fragmentation in this space. And it can be quite confusing for the patient and certainly challenging for the providers. What you're seeing is many of these kinds of pure-play players. If you think about chronic disease management, you've got players around lower back pain. In behavioral health, you've got players that are specific to teenage eating disorders. Because

there's so much fragmentation, now suddenly you're getting kind of umbrella companies. Some are taking risk, like Transparent, which is wrapping many of these services together in experience. Some, like Virgin Health, are also trying to do that but with focus on the employer community. It's fragmented, and there needs to be more clarity.

Just so you guys have a clear context of the services that we offer at this point in time, and this has been something that we've been building. We started with just real basics. We started during a pandemic, so it was about testing and treatment of COVID. And, then vaccinations. And, then we could roll into more preventative care. And, then we rolled out pediatrics and integrated behavioral health. We've got several other products that are coming online. It comes down to bridging the gap between, on the one hand, the inconveniences but full-service scope of a traditional brick-and-mortar environment and, on the other hand, the scope limitations yet high convenience of the telemed-only piece. We have experienced the pluses and minuses of brick and mortar versus telemed only. Because we're able to provide that full experience, including both the virtual component and the hands-on piece, with our mobile care teams, there is no compromise in the care quality between the pediatrician's office, urgent care, or primary care and our offering.

My interpretation of that is what you're going for sounds like more traditional care, but delivered through an integrated means of virtual plus brick and mortar, plus mobile home care. So, a more holistic approach relative to other groups that are approaching sub-segments of the holistic ecosystem, whether it's focusing on a particular disease or focusing on particular parts of care such as chronic care management. Is that a fair summation?

That was a good summation. If you suddenly see a lot of employers embracing direct primary care, this is a problem, right? What we're seeing is you've got these innovators coming in and saying, "Hey, we can solve for bits of healthcare, some of the convenience, such as 24/7 virtual care, or some of the integrated behavioral health pieces, but we're going to do it outside of the system and fundamentally compete with the system. Compete financially, largely outside of your benefits, and compete clinically." We believe that's a problem. The traditional system has a huge amount going for it. What we're looking to do is create a direct primary care wrapper that you can plug into your traditional primary care or pediatrics. So, now your traditional player can offer that concierge-type experience, but it will all be within your benefits.

Very helpful, thank you. Let's talk about the benefits of this integrated model that wraps around brick-and-mortar coordinated with these other types of virtual services. What are the benefits that the healthcare system should expect, as well as what are the benefits the patient should expect?

And, even throwing in there that mix about the providers – what are the benefits to them? Tom's got a deep view on this, but I'll take a crack at it as well. From the patient's perspective, just one example. We've had several testimonials from moms, who still make the majority of healthcare decisions in the country, who expressed to us that the Ascend model allows them to get the care they need instead of them just quarterbacking care for a partner and for their children, or going without care because it was so inconvenient. That's just one example of being able to meet patients where they're at virtually or mobile. For providers, the easiest way to summarize this is that one of our advanced practice practitioners summered in France with their family while they were doing virtual care at Ascend. So, amazing lifestyle flexibility. And then, for health systems and payers who are large stakeholders, we are something that can bend the cost curve. Delivering care in a brick-and-mortar, I know it from my real estate background, I know what it costs to build it. I know what it costs to maintain it. I know what it costs to finance it. It's a huge cost add-on to health systems and to payers for this. If we can start chipping away at some of that cost structure by doing these virtual and mobile models, then there are huge benefits, not only economically but also clinically, because of increased utilization.

Let's just look at the evolution of the consumer. Pre-COVID, virtual care was almost non-existent. It was so small. Then, obviously, it had to explode during COVID. There were a couple of things there. One is that to the consumers, it was still awkward. It was new. It was, "How do I consume this?" And second, the technology could have been better. I mean, everybody saw the Teladoc stock shoot up and then collapse. It just needed to be delivered.

What we are seeing is an evolution on both the consumer front and the technology front. So, as consumers start to embrace more of these types of virtual care, you're seeing a lot of innovation.

We're seeing especially around weight loss and men's health, especially anything with a stigma; virtual seems to be preferred over in-person. And, I mean, that's still the minority of healthcare. And certainly, if you ask consumers where they want to get the majority of their healthcare, in person, in a physical building is still much the preference. But, as technology improves, you are starting to see a shift in the consumer. And then, from the provider's perspective, this could be a kind of

scary time. You could look at it and say, "These innovators are starting to chip away at my patients." Suddenly, the business is starting to move away from the traditional primary care practice. But, at the same time, if you consider that erectile dysfunction is one of the highest indicators of early heart disease, you want that type of service in your primary care practice. You want that integrated. And so, by creating easy, intuitive access to these virtual and mobile services that can plug into your traditional model, the traditional primary care practices can be extremely competitive, even against some of these telemedicine newcomers. And within that, there are some interesting new profit pools and revenue opportunities for traditional providers.

When I think about some of the recent big trends in healthcare, it's interesting that each of them seems to have a catalyst and an incentive and a sponsor. For a big theme of value-based care, I'd say that CMS really stepped up as a sponsor of value-based care, and others then followed on. There were incentives to drive the market, whereby CMS really said, "This is where we're going." CMS has had many iterations of their value-based care programs over time, but within each, they defined incentivizes for groups to change their behavior and follow the direction that they were looking to push the market in. Consolidation has been another big trend in the healthcare market over the past five to 10 years. Arguably, private equity was the sponsor of that movement. The catalyst there was the deployment of capital to consolidate these fragmented practices into organized MSOs. What you are talking about feels like another big shift in the market - the concept of integrated brick-and-mortar plus virtual and mobile care. And, it too, will require investment and change in behavior. I'm wondering if there is a sponsor that's emerging in the market - whether it's private equity, whether it's CMS, whether it's consumers - driving adoption and incentivizing adoption to really take what you're referring to and drive much broader proliferation and adoption across the market.

A lot of the concepts are there, and I'll address a couple of them here. We've done some pilots with some of the MA groups and for their "unreachables." CMS has been relatively disappointed in what the commercial payers have been able to do on this side about increasing utilization, improving healthcare outcomes, and lowering costs. They've been good at getting people to sign up for it, but it hasn't changed the fact that access is still an issue. We had a pilot where we were able to reach and have the visits for 80% of the "unreachables" in a particular pool. So, that's going to be really appealing to CMS and payers. It also shows the power to health systems, and then also to private equity. Groups like Ascend and others are demonstrating that you can engage people in a way that gets them to be seen and treated, to identify disease states, and to get on prevention and care plans where traditional groups otherwise couldn't. So, you are going to see the market consolidate even more. We've all seen these massive deals with Oak Street, Signify, etc. At every conference I go to since the spring, every private equity group, every health system - whether it's their chief strategy officer or even their real estate executives - are talking about the importance of hospital at home, healthcare at home.

The change in reimbursement from CMS around the hospital for the home area is having an enormous impact on our industry. There is a McKinsey report that suggested about $285 billion worth of Medicare spending is going to be shifted to home-eligible services by 2025. So, it's not surprising you're seeing an absolute windfall in terms of new entrants getting into the space. CMS is, far and away, the biggest driver. I might point to a couple of other drivers. One, innovation itself is creating new opportunities. If you think about home dialysis, that's transformative if you've got renal failure. And, then the other one I might mention is also the employers. And this is a little more hidden, but these employers are getting absolutely crushed by healthcare spending. And even though we're predicted to grow 4% to 7% over the next five years of medical cost inflation, I speak to a lot of these employers, and they're desperately looking for solutions. And, as Jason mentioned, the traditional models are failing them. And so, they're really starting to hunt out innovators in the space. They're really looking to avoid the PMPMs.

They're looking to engage in traditional healthcare to solve this problem. And that creates a unique opportunity for companies like Ascend.

You mentioned hospital at home. You mentioned a number of primary care use cases. You mentioned dialysis. As you look out over the next five years, is the concept of virtual care something that you think all MSOs of all specialties need to be thinking about in their strategy? What is their use case? What is their execution strategy? What is their value proposition within virtual care? Or do you see it more narrowly, that this is really applicable to certain pockets of the market like primary care, dialysis and hospital at home, but not necessarily relevant to neurology, ortho, or pick your other specialty?

One of my friends runs orthopedics for one of the four largest health systems in Georgia. And they're talking to us about how to leverage Ascend's mobile teams to help with mobile X-rays. We're seeing two-week backlogs, sometimes three-week backlogs,

across ortho practices for imaging –people are suffering and their patients hate the delays. That is an anecdote I just thought of when you mentioned the question. So, I think it depends, is the short answer, but I think every specialty has got to make an assessment of what can be done virtually, what must be done in a brick and mortar, and what can be done at home or at a patient's place of business. We have to ask these questions because all of these access points have different costs of delivery and, frankly, utilization rates too. It's a complex formula, but ultimately virtual and mobile care increases access and can increase utilization. That's what we're all after.

I've been deep in large, multi-specialty groups, and certainly seeing just the power of virtual care in these areas, I think it is huge and universal. Certainly, some specialties like behavioral health, are obviously shifting a lot more quickly to the virtual environment. If you think about cardiology, your CHF patients, especially the more acute ones, can be managed far more effectively with things like remote patient monitoring. Endocrinology is another one where there are so many access challenges, it suddenly makes you think about how you leverage things like APPs and virtual care to create just a better model for your patients and a better model economically for you. And so, a few areas that we saw over at Optum, for example, the cost of having a full-care team in our neurology department, just meant that an average neurology visit was around $300 to deliver for us - so, pretty damn expensive. But when we were doing virtual neurology for just certain types of use cases like epilepsy, we were able to get the cost down to $100 a visit. We didn't need nurses. We only needed a portion of the staff. We didn't need the building. And so, it started challenging us to say, "Hey, well, as physicians, you've always got some patients who want virtual." Let's say you have a practice with four docs, right? If you can start saying, " My Mondays are going to be my virtual day, and Tuesdays are going to be your virtual day." Well, now you can suddenly fit an extra doctor in the practice, leverage that same care team and that same cost of real estate, and depreciate it over five doctors instead of four doctors, for example.

There are lots of different pockets in terms of delighting patients, increasing access, improving quality, and improving unit economics that make the smart use of virtual care a really powerful tool, both in primary care and in the specialty.

Much like some of those other big healthcare trends - value-based care and consolidation - I suspect with this trend of virtual and mobile care that you'll get some groups that will get it right and some groups that will really struggle and over-invest, under-invest, or just have partial or confused rollouts. Can you talk about what a mature, integrated brick-and-mortar virtual care program looks like from a best practice perspective? A couple of questions that come to mind. Are the remote care teams the same as your in-clinic teams - one patient you're seeing is in the clinic, and then the next minute, you're on a telehealth visit? What are the other supporting teams that are required to execute effectively on virtual care programs? What's the backend infrastructure that's required, and what investment is required to execute?

It's an annoying answer, but it depends. One thing I would say is as you start really looking at the model, one big question is around scale. Certain models work far better with scale. If you think about on-demand urgent care, to do that type of model, you need people sitting around waiting and just being ready to take that call. It's hard if you don't have a large patient volume. We've tried doing this before where you've got folks sitting in practice, and it's, "Oh, well, while I'm not busy, I'm going to jump into this on-demand urgent care." The customers for the urgent care channel very heavy on Monday mornings. If everybody's busy on Monday mornings, that could be more helpful for the consumer, for example. But then if you start thinking about behavioral health driving to more specialization, you've got a psychologist who's really good with ADHD patients, or it might be with your teenage bulimics. You really want to start navigating those patients to those specialists. When you add more specialization, you need more scale to be able to get to your capacity utilization. So much of this is really about the economic model, and it's the old expression, fannies on seats, right? If you're not filling the appointments, then typically, your virtual care model under a fee-for-service paradigm is going to be unprofitable. And so, how do you evolve that into a value-based model that has a whole bunch of other considerations? Or, if you've got a lot of scale, it gives you a lot more flexibility to really build out a mature program. If you've got less scale, it really challenges you to think more about partnership rather than do it yourself.

To expand upon that last topic of partnership, you mentioned scale and specialization as key concepts, which not every group is going to necessarily achieve. Can you talk about that concept of partnership and how you see that playing out? This feels like a potential catalyst to have real, organized coordination across B2B partnerships. So, if I'm a large urology MSO, I can be a urology brick-and-mortar plus operate as a urology specialty virtual care solution for another practice that doesn't specialize in urology. How does this play out? Who goes and builds all of these capabilities out in-house, versus do you see this really being a catalyst for a much more organized inter-specialty B2B partnership?

That's a perfect example, urology. Back to our practice. We had these prostate surgeons who basically cut two days a week, and were in the clinic three days a week. And really looking at the economics and seeing the patient flow, when we dove into it, we observed that a lot of the patient flow was really around things like erectile dysfunction, where patients would never really need prostate surgery. So, we thought about redesigning the program. We said, "Hey, look, a lot of this ED workflow can be done by APPs. And so, if we could navigate those types of referrals into our APP queue, that could free up our prostate surgeons who could then have more surgical yield and they could then cut three or four days a week versus the two days a week." So, that was obviously hugely beneficial to them. But then you start thinking, okay, well, those ED visits, do they really need to be in practice? If we could have specialized APP in the urology space, then these could become part of a virtual pool. There are a lot of new techniques, like e-visits, which are very good for a lot of these sorts of asynchronous care for a lot of these erectile dysfunction patients. Leveraging new technologies and centralized care delivery, these urologists don't necessarily have to have a fixed cost of hiring these APPs full time. They can rent a pool from somebody like ourselves and be able to increase their surgical yield and, essentially, their take-home pay at the end of the day.

That last topic is interesting, really the last two combined. So, scale, specialization, partnership – and, that really speaks to a cultural shift across the entire market. It's not just about cultural shifts within an organization, but really, we're getting into how businesses interact with each other and coordinate with each other. When you think about moving from where we are today to where we're going to be in five, maybe even ten years, because these trends do take time to reach their maturity, what are some of the key changes that are going to be needed at a broader market level? Whether it's reimbursement, whether it's regulations around how different healthcare tax IDs can coordinate with each other, whether it's provider compensation? What part of our day-to-day that we take for granted or take as fact is really going to need to change in order to see this reach its full manifestation?

There are several things that need to happen. On the provider side, this is something that we've been seeing here. There's so much burnout, and there's been so much compression on reimbursement and, therefore, incomes for primary care docs. There are so many just getting pushed right out of the market. They're stopping the practice, or they're just desperate. But yet, independents still make up a large percentage of primary care clinics across the country. I think the headwinds that they've been facing have conditioned them to be more open to possibilities. And that provides an opportunity for us at Ascend. Clearly, that's on the partnership level. My initial thoughts were it would be health systems, like what I did with my urgent care. And, we're still doing that. But, there's a real opportunity that Tom has really helped us expand our vision to, which is with these smaller independents.

Provide them that lifeline to help them basically make the most economically with their lifestyle. And more importantly, and then just as importantly for us and our business and our own patients, is making sure that we can increase access to care.

One of the real challenges is integrating all these fragmented pieces together. So, somebody comes, "Oh, well, I can provide this telemedicine service," and somehow expects, especially these smaller practices, to somehow integrate these all experientially and technologically. It's a really big challenge that makes you think there must be a better way. What we're going to start seeing is a platformization, a made-up word, right? In healthcare, fundamentally, we need that front-end digital consumer experience that integrates very nicely with the back of these health systems. So, that challenges folks like us who have care delivery offerings to integrate with the front end, the digital front door, as well as functions like revenue cycle, and integrate these into a scalable platform. And that was one of the things that excited us about working with SCALE. Obviously, we're a small company. There's a lot in that platformization and we can only help out with a piece of it. But, if we can start putting those pieces together, both smaller practices and MSOs can embrace the platform rather than necessarily having to pick and choose and having to do all this technology integration themselves. That could see a massive uptake in these types of solutions.

Here are a few thoughts to lay the groundwork for the question. One is that it's not patient preferences that drive change in healthcare. We're in a paradigm that's driven by cost savings right now. And so, if it was patient preferences, the whole world would convert to concierge overnight. But the payer community, whether it's government or commercial, focusing on more efficient healthcare drives where incentives go. And so, you are shifting the paradigm in virtual care from "can we create a fee-for-service virtual care platform" to "can we integrate it into a value-based care, cost-orientated, savings-orientated platform?" And that is a

shift for virtual care, but a very healthy one. If you look at a primary care practice 20 years ago and compare it to what you think of a primary care practice today, the difference is mind-numbing, right? One was a relatively contained, small business that focused on referrals to specialists. The other is rapidly becoming a fully integrated, multi-specialty business with a value-based care program with multiple departments driving that value-based program as it migrates into multi-specialty. And, now we're adding virtual care as well. And so, Tom, your point about what small primary care practices really do is a really important question. And then we have these analogies. We have these comparisons of change in healthcare. What's interesting is that it's only sometimes the largest players that adopt the greatest change. Health systems in value-based care have mostly been a failure, whereas outpatient multi-specialty and value-based care have mostly been a success. I see and expect to see more value-based care adoption from a small, multi-specialty, independent groups with 10-50,000 lives than I expect to see from a large hospital. And so, who's driving the change, how and why is very interesting. In the continuum of change, we see different actors adopting different levels of change depending on what's available and depending on what suits their risk-return profile. So, being part of an IPA and participating in a value-based care program versus forming the IPA versus creating your own full-risk program are all different stages in the continuum of change. As you think about the change that you're injecting into the marketplace, different actors will respond to it in different ways. And that brings me to my question. As you look at all these different actors, the end markets, and the target markets for your group, why pick the employer marketplace versus the provider marketplace? You mentioned, Tom, how many providers will want to adopt some of this but will need your help versus the direct-to-patient, "let's be One Medical" and get our own virtual patients while also supporting them with brick and mortar. You have three very different marketplaces that have very different needs. Why pick one versus the other? And how do you think that each market has different needs from you?

You named all the major constituents in this, all the stakeholders. And so, care delivery is care delivery, and there's just these different components of it. At Ascend, we need to have offerings for employers, for payers, for health systems, and for smaller provider groups. The hardest one is to go direct to patients. And, we have been doing that, but going right to the patient, to the consumer like One Medical, is just a bare-knuckle blood sport to be earning those patients. And then groups like One Medical still have the issue of their offering still promotes patients "cheating on them" and having to go elsewhere for different components. Whereas, our model is not only more advanced in its practice, it's holistic and can be a better catchall so that we can minimize that, which is appealing to employers, which is appealing to these provider groups that we could partner with. And it's obviously, just on a larger scale, the health systems, there's appeal there too. Health system just take 18 to 24 months to get any deal done. But the smaller groups, smaller physician groups, we can do that now. My last thought on that before I turn it over to Tom is that I was at a conference in Dallas last week on healthcare and the attendees included attorneys that represent physician groups, primary care physician groups across Texas and the Southeast. The attorneys approached us after one of my talks to say, "Our providers need help. They need to talk with groups like you. They know they need to offer these services to their patients, and they just don't know how to do it. They don't know how to build it. They certainly don't have the resources to buy it. Let's explore this with Ascend." And we're going to be able to do that with all these stakeholders, large and small.

Is there a sensitivity amongst provider groups with patient attribution? They would like you to build less clinical capabilities and more technology infrastructure versus employers who may want the exact opposite, "Hey, we want to rely on you for a full turnkey service, including clinical?" And so, do the two markets look for very different solutions?

I think they do, and Tom's definitely got a point of view on it. I will say this, though. The patient attribution for some provider groups is incredibly important, and they are very sensitive to it. And we're fine with that. We have the direct-to-consumer side of our business. We don't anticipate ever letting go of that, and we'll continue to grow it, but we want to be that preferred partner to those providers where, with integration and interoperability of the EMR, they know they get to keep their patients. They can bill them through the revenue cycle. We negotiate our own economics with them that makes sense for us, but they get to keep that patient.

And so, we're going to be able to, with this group of stakeholders, we're going to be able to give them each of them what we need. But it takes time - this is not something we just thought of and delivered overnight.

We've been doing this for three years now and still have some more development, some baking time before these partnerships, and these models are really going to be mature and ready to scale nationally.

So, the real thesis is growth through partnership. We really want to grow primarily through partnering with existing practices. When it comes to attribution, the last thing you want to do is be seen as competing with these existing practices. Our model is an APP-led model where our APPs can essentially sit underneath the existing primary care docs within these practices. And so, there's real clarity around the attribution models. To get to a place where you are able to provide the full direct primary care plugin model, you have to build the capabilities. And so, really using a lot of these direct-to-consumer and direct-to-employer type retail models to help us build these capabilities that we can then go and offer and extend to others. The one benefit there is that as we're doing this, we're really learning capabilities in retail - how do you acquire customers? And not all customers are the same, right? And how do you acquire profitable customers? I think that as we build those types of capabilities, we can then go and extend the capabilities to our partners in these practices so that not only can they really improve the experience they're offering their patients, but they can get this bolt-on customer acquisition engine that can help improve their patient mix and improve just the volume coming through their practices.

At the beginning of the year, in partnership with the Medical Association of Georgia, I launched a platform called Indie Practice to help independent medical practices, of which I'm an advocate, increase revenue, save cost, and protect themselves. The centerpiece of that through webinars has been remote patient monitoring as a revenue source for primary care. I've been shocked and surprised at the level of inertia amongst them in making a change. And the change obviously benefits them. The biggest block to me seems to be the collective leadership IQ of many of those independent practices. And they need leadership, and they need guidance. Anything that we can do in that regard is a good thing. As I said, I'm a fierce and passionate advocate of independent medical practice, and primary care is the foundation of that. How do you address that the question of inertia versus entrepreneurialism at the leadership level for these independent practices?

So, I was sitting in Baylor Scott & White, using 12 billion systems where we managed all these primary care docs, and I ran into exactly the same problem. It's, "Oh, this remote patient monitoring thing seems like an awful amount of hard work." But then I'm digging into that and seeing that one of the biggest challenges is around clinical integration. And so, you can outsource remote patient monitoring to one of 50 different vendors who will go do that, and then you end up getting fax sheets back, and data needs to be more well integrated. I think when I look at remote patient monitoring and just, in general with primary care, being able to package these things in a way that's simple, easy and integrated - so that clinical integration component is such a powerful piece to this. And that sometimes comes back to, once again, that platformization. We have to work through 20 different EMRs and different models - it becomes hard work. And then it's, "Oh, my IT guy doesn't really want to do it," and you don't know why he doesn't want to do it. It might be because he needs to understand it, or it could be because he's lazy, but you have too many stakeholders to have to win over. We used to say a 99-to-one vote is a tie. Everybody's got a veto. And so, it takes a lot of work to get these innovation technologies loaded. Really, the challenge for the innovators is how do you make everything so integrated, so easy?

And so, remote patient monitoring is definitely one area where we are, rather than trying to build out that whole capability, we are looking to partner with a best-in-class provider that has really well-integrated technology.

Sometimes that's a little bit more expensive, but you get just better outcomes both financially and clinically for your patients.

Yesterday, I arranged a presentation for remote patient monitoring into a mental health practice, a busy psychiatric practice, and it seemed to be going pretty well. They obviously needed the revenue until the RPM company said that they needed to connect directly to their EMR, and the doctors just froze. The IT guy was there, and I generally find these days that IT is the weakest link. And they're like general counsel. They're always spring-loaded to say no. IT and lawyers always say no, and you can never penalize them for that. And so, anyway, I applaud what you're doing. Easy always sells. If you simplify it and get past that leadership inertia in these practices, it will move faster.

We won't be a fit for everybody because there's a lot of independence in those independent practice leaders, but the ones who get it, the ones who see it, are going to look at the offering, and it'll be essentially turnkey. And they get the best of all worlds, and we do all the heavy lifting for them. That's hard to turn down, but they deserve it. I agree with you that independents are the backbone of the country, and not just in healthcare, but we need to find ways to help support them and help keep them around. And they've got a very valuable contribution to make, and they still need to have a fair shake.