Kevin Riddleberger

Ann Elkins: Well, I started talking with Kevin Riddleberger a few months ago, and I was very excited by the fact that they are truly coming in to disrupt the health care industry and how health care is being delivered. So this'll be very fascinating to listen to.

Dispatch Health provides mobile and virtual health care in more than a dozen cities. And Kevin is the cofounder and chief strategy officer there. He has 20 years of clinical and management experience in the industry and a passion for redefining care delivery through technology, process and quality improvement. He was previously head of clinical solutions and strategy at iTriage, where he was also a physician assistant for 15 years, which I find fascinating. So, without further ado, please welcome Kevin Riddleberger.

Kevin Riddleberger: We saw that there was an opportunity to be able to look at areas of the $4 trillion health care system. And if you break that down, about 750 billion of that is probably considered waste. And so of that $750 billion, we broke it down and looked at the ER experience.

And so I want you all to be able to think about the last time that you or a loved one went to the ER. And I want you to think about that experience from the time that you were thinking that "I need care" for that acute illness or injury, that thought process and being able to take yourself or a loved one to the emergency department.

Probably not a great experience, as well as it was a very complex and confusing experience. We've not done a great job as clinicians, as leaders, to make this easy for patients. If you think about all the different innovations out there or ways to think about health care access differently—you have your typical ER, you have now, urgent cares that are popping up, you have freestanding emergency departments, you have your own primary care physician, you have virtual health that is available.

Now, what is the right solution for you or a loved one at that given time? It’s very confusing. We're not all clinicians so we don't know exactly how acute or serious that illness or injury is and what level of care I need, to be able to get the most appropriate care at the most cost efficient manner.

If you look at some of the statistics, 37 percent of ER visits really don't need to be in the emergency department, and that's probably very conservative. There are some studies out there that say 70 percent of the visits inside the emergency department really don't need to be in the emergency department.

If you look at the quality of care, and the way that I'm defining quality of care in that emergency department is, as patients get treated in the emergency department, how do they transition back into the care delivery system?

Do they get back in to their primary care physician? Do they need further care for that acute illness or injury? And studies show 20 percent of the time, those individuals actually end up back into the emergency department within 30 days of being seen in that ER. If you look at the hospital, and if you are admitted to the hospital, 20 percent of the time when you're transitioning out of the hospital, you are bouncing back into that hospital.

And so there is a gap and fragmentation that occurs in health care where we can't transition patients successfully back into the hands of their primary care physician or internist. There's a gap where patients just fall through the cracks and they end up back into the hospital or the emergency department.

So we wanted to do something about that. And I want you to go through, and I want to dig into a little bit deeper around that ER experience. And there are a lot of different personas on how people end up in the emergency department.

And so if you looked at a senior who is living in an assisted living or in an independent living community, that experience is really calling 911.

You may have a fire truck, you may have an ambulance show up with lights and sirens to be able to transport that individual to the emergency department. Those facilities are really real estate facilities. They're not health care communities, and so they are trained, when in doubt, call 911, and so all of their colleagues and other residents within those communities know, when Mrs. Smith is sick or injured, you have lights and sirens that show up into those communities. And that's an expense. And so if you look at the typical ambulance ride, in Colorado, the typical ambulance ride is about a thousand dollars. When you look at the typical ER costs, it's about $2,200.

What if we were able to disrupt that and to be able to provide care at that senior community and disrupt the ability, that they would not have to call 911.They would not have to be seen in the emergency department and maybe that senior's not going to decompensate when they're inside of that ER or inside that hospital.

That's not even taking into consideration family members getting called, you know, at 5:00 p.m. saying mom or dad is being transported to the ER for a nosebleed. And that's a very common occurrence. What if we did something

a little bit different to be able to disrupt that? And that's really how Dispatch Health got its start, is to be able to provide high acuity care inside the home.

And we got this start back in 2013. In 2013, myself and my cofounder partnered with an EMS agency in Colorado, to be able to place a ER trained nurse practitioner—a PA—in with a community paramedic EMS vehicle to be able to respond to low acuity 911 calls. Across the country about 17 to 25 percent of ER or 911 calls really don't need to be transported to the ER. And so that was really the demographic we wanted to study and to determine could we make a positive impact on the experience? Could we make it a positive impact on the costs? Could we actually provide great clinical care inside the home versus transporting that individual via the ambulance and seeing them in the emergency department?

So we did that. And we studied that, for about 18 months. And we looked at what type of clinical equipment could we put in a vehicle to safely treat individuals inside the home. We looked at what type of outcomes were we having? Could we coordinate that care afterwards and make sure that they're getting back into their primary care physician after we treated them, or were they just getting back on the hamster wheel and calling 911 and ending up in the ER seven days, 14 days, 30 days later.

And we also wanted to look at the impact in terms of the value that we were creating and were we really bending the cost curve on those individuals. And we saw tremendous results. We saved about a million dollars over the course of that 18 months, when you take into account the average cost of the ambulance ride, the average cost of the ER visit.

We knew that we were actually truly saving that money because we also tracked this individual for 30 days afterwards to determine were they truly staying out of the emergency department and the hospital for the same related complaint to the care that we were providing inside the home.

And so we determined based on that 20 percent nationally were they actually staying out of the ER and we were able to show 7 percent of the time, they were actually staying out of the emergency department. So that resulted in the million dollars. That resulted in us being able to go back to the insurance companies to say, hey, I think there's some value that we're creating here. I think we're doing your members some favors and your company some favors by actually saving some money on this experience. So we were able to contract in Colorado with all of the insurance companies in Colorado, the Medicare Advantage plans, the commercial plans, and then we also

uncovered some CMS, Medicaid and Medicare codes that we could use to be able to treat those individuals inside the home.

So at that time, in 2015, we said, "I think this is a great business." We left our jobs and put both feet into this thing to be able to scale it. So we raised a little bit of capital. We brought over some software developers from our previous life to be able to start to build technology to enable this type of care inside the home.

And we put vehicles on the road like you're seeing in the photo here for individuals to be able to access us directly, outside the 911 system. So individuals with acute illnesses and injuries could call us directly. They could actually use a mobile app that we built to be able to request care, or they could go on our website to be able to request care.

Our first partners in the space were individuals that were actually calling 911 that really didn't need to be transported to the ER. So we worked closely with senior communities in the Denver Metro area to be able to offer an alternative for them, to call us, for them to screen them ahead of time to make sure that we were clinically appropriate.

And then we sent out the team to be able to take care of them inside the home. And so in August 17, 2015, we put our first vehicle on the road outside of the 911 system and started to take care of patients and started to build technology to be able to enable this.

Fast forward, now, we're in a few more markets than was described just now. So we just opened our 16th market across the U.S. We're now in 11 states in the U.S., delivering acute care inside the home. We did about 32,000 visits last year. We'll do about 90,000 visits this year. We'll open our 17th market in December of this year, which will be in Atlanta, Georgia. Happy to go through the markets that we operate in, but, you know, inside every one of those markets, we partner with the insurance companies. We partner with strategic health systems to be an option for them. We partner with really everyone across the continuum of care. So that could be care management groups. That could be inpatient case management groups, home health agencies, senior communities, primary care physicians, specialists, really to be an adjunct or another tool that they could be leveraging for those individuals that have acute needs.

So every patient that comes through Dispatch Health, we want to screen up front to make sure that we're clinically appropriate to send out a medical team inside the home. And so we've built some technology to be able to risk-stratify those individuals. So based on their age, based on their chief

complaint, based on their gender, we surface up, follow-up questions to determine the level of risk, for us to send a medical team out to that individual's home to take care of them.

For a low risk individual, we'll go through and collect further demographic information. We'll collect their insurance information. We'll do a real-time eligibility check to make sure that the service is covered with their insurance. We'll provide some price transparency to them to make sure that they feel comfortable around what the potential costs could be for this service in the home.

A lot of times as consumers, in the health care space, we don't trust a lot of the different services that are out there because we get hit with these large bills afterwards. A lot of freestanding emergency departments are popping up across the country. They've looked like urgent cares, but they bill like emergency departments, and those individuals will get hit with some very, very pricey bills afterwards.

So we wanted to be able to change that a little bit to be able to have that price transparency up front, to be able to build some confidence in that relationship that we are establishing with that patient.

If the patient has a condition that we are unsure about or is in that gray zone with our risk stratification tool, we'll get on the phone with them, with one of our ER trained nurse practitioners, PAs or physicians to be able to review more what's going on with them at that given time, again, to make sure that we are very confident about sending a medical team out inside their home. If it is clinically appropriate, we've built a logistics platform to be able to mobilize these vehicles in a timely manner out into the home. On average from the time that you request care to the time that our providers reach the home, we are there within two hours. That varies based on the time of day, day of the week or the market that we're operating in. But on average across all of our markets it’s within two hours.

The team that arrives inside the home is really a medical team. It's just not one individual that arrives; it's a team of clinicians arriving inside the home. So in the vehicle, we always have two individuals that are arriving inside the home. One of the individuals is what we call a Dispatch Health medical technician. Usually an EMT trained individual that is driving the vehicle, is there for efficiency purposes and safety purposes when we are treating patients inside the home. The second individual is an ER trained nurse practitioner or PA delivering the care. And then we have an ER trained locally

licensed physician available telephonically to be able to review cases with the patient or the nurse practitioner or PA, if need be.

So that's the team that's arriving every day to a patient's home. The equipment that we bring inside the home—this is not your typical house call, and the house call you're thinking about, back in the 1940s, that would treat about 40 percent of all health care visits—this is much, much different. We arrive in a vehicle that's branded as Dispatch Health with about 70 percent of what you would typically see in the emergency department. So this is really a house call on steroids, is what I like to call it. We bring a CLIA certified lab, so being able to provide point-of-care lab testing, being able to start IVs, IV fluids, provide antiemetics, IV steroids, IV antibiotics. Being able to provide Lasix, being able to pack or cauterize nosebleeds, place a Foley catheter, Coude catheter, replace G-tubes, to being able to do neb treatments. We bring a 12-lead EKG, so a wide range of capabilities to be able to treat some pretty sick folks safely inside the home.

This is not a concierge service; this is a service that's really available for all ages. We skew pretty heavily in the geriatric space, so an average age of about 68 years old for the care that we provide.

And we contract with every payer, and that includes Medicaid. That includes managed Medicaid plans in those markets. So it does not matter relative to your wealth or income at all. When you have an acute illness or injury, we are available to be able to take care of them conveniently and comfortably inside the home.

Once we arrive on scene, we're there on average 42 minutes. So this is a face to face encounter that we are treating them in their living room, on their couch, for 42 minutes. Once we complete that care, it's really about coordinating and making sure that we're tucking them back in with their primary care physician or specialist. So we want to make sure that we're calling them when we're on scene. We want to make sure that we're getting our clinical notes over to them within 24 hours, making sure that this is a very integrated and coordinated experience.

We work with health systems across the country. We work with payers across the country to make sure that we are not just a fragmented piece of care delivery, but making sure that we're tightly integrated with their processes.

After that care is delivered, we call every patient back three days later, to make sure they're doing okay, making sure they don't have any questions regarding their care plan, making sure they are following up with their primary care physician. And then that's really where our care delivery stops, is

for that acute episodic treatment. We want to make sure that it's coordinated, we're not disrupting that continuity of care with the pediatrician, with the primary care physician, internist, and they're maintaining their chronic disease management for that patient.

So flipping the care experience. So this was very first, top of mind for us, and there's a book out there by Dr. Eric Topol, if you have not read it, I recommend you read it, *The Patient Will See You Now.* And that's really our mentality. This is a picture of our team arriving inside the home and making it convenient as possible for that patient (photo). And they choose when they want to be seen from our team. It's not what's convenient for our providers, but what's convenient for that patient. And the reason behind that is the health care consumer has changed. If you think about everyday experiences in life, we're able to get and have a lot of convenience, and being able to get services and goods delivered to our home in a timely manner and very easy manner.

So we wanted to be able to provide that experience also with health care. There's not much of that out there today, when you think about health care and making it as convenient as possible, making the cost transparent to the consumer and making sure the access is available. We're getting better and better in being able to provide these services to our patients, to our consumers. But we have a long way to go to be able to meet the Amazons of the world and change that health care experience.

So why is this better for patients? If you think about the last time that you went into the physician's office—and my wife is also a clinician, and we actually talk about the weight scale inside the hallway all the time—it was just very funny that was brought up. But this is an experience where it's their waiting room, it's their exam room, it's their clothes that they're wearing, it's their health care. And we really want to make sure that we're following with the needs of the patient to be able to age in place.

And the flip side to that is that we want to make sure that this is a great experience for our providers, as well. They went into medicine to be able to take care of patients. They didn't go into medicine and I didn't go into medicine to be able to chart, to be able to bill and to be able to fumble through technology. So we're able to provide a different experience for our provider teams as well, and to be able to have a different level of interaction with this patient. You can think about and let your minds go in terms of what we've seen inside of homes and what we've done inside the homes over the last six years. We've sutured kids on their kitchen counters, while they're in a familiar environment; much, much different than papoosing them down on a

bed inside of the emergency department, to be able to provide that same level of procedure. We're sitting down with patients on their couch, right next to them.

And it's a different conversation with those patients and we're able to elevate that patient and provider interaction together. We provided a technology to make this as easy as possible for our providers, too, so they can remove the barrier of technology and have that patient provider experience as best as possible inside the home.

So how are we doing? We've talked about how we've expanded a great deal. We have raised about $75 million to be able to scale this across the country over the last six years. And our aim, and you think about the triple aim, assume a lot of people have talked or heard about the triple aim, what it's really about—cost, quality and experience. We think about it actually as the quadruple aim. So we want to make sure that we're actually providing great experiences for our providers, as well.

If you break down what we've done, if you look at the patient experience, we track patient experience by tracking the net promoter score. This is a survey that's done in a variety of different industries to be able to determine how likely would they recommend this service to a loved one or family. And our net promoter score has been 95 since we started this, and that is from just over 75,000 different reviews. If you compare that to a typical net promoter score in the health care industry, that score is around 30 for a typical health system or health insurance company. So we've really focused to make sure that this is the best experience that a patient has ever encountered accessing health care from the time that they request care to the time that we coordinate that care back into their primary care physician.

Cost reduction. Have we actually moved the needle in terms of providing savings to the system? Last year we did about 32,000 visits across the U.S., and we saved $70.8 million. And when you calculate that, it is really calculated by, did we remove individuals from that 17 to 25 percent of individuals calling 911 that really didn't need to be transported? Did they really need to be in the emergency department? Would they have been admitted to the hospital for an admission or observational status?

And as you can probably imagine, as we've scaled across the country and work really closely with health insurance companies, we've been somewhat scrutinized during that time to determine how real is that $70.8 million. There are some people right here in this great state of Minnesota that have a large insurance company that have looked under the covers to say, is this really working? And we've gotten their stamp of approval to be able to contract all

across the country with a national agreement with them. So this has been validated by all the bigwigs from the insurance companies in terms of the actual value creation with savings for those patients.

And in the clinical outcomes, we measure those clinical outcomes by maintaining and making sure that we are keeping people out of the emergency department after the care we deliver. We want to make sure that we are actually coordinating that care and making sure that we're integral in getting that patient back to the primary care physician and making sure they're not ending back in the emergency department. And we're seeing 9 percent of individuals for the same related complaint need the ER afterwards compared to that 20 percent in that study that ultimately end up in the emergency department.

So what's next? We think about how do we move the needle more and more in transforming facility-based care. And so we started with EMS. We continue to operate in EMS, and there's a lot of great innovation actually happening in EMS right now, out of CMS, to be able to incentivize EMS companies to look at alternatives to take care of those folks outside of the emergency department. So we're continuing to operate within the EMS world and integrating with EMS.

We'll continue to provide acute level of care, an ER level of care inside the home. Next year, we should be in about 25 markets delivering this level of care and partnering with insurance companies and health systems across the country to be able to deliver this type of care.

Moving forward, and starting actually next week, we are looking, and we'll be executing on, delivering skilled nursing facility care and hospital level of care inside the home.

Sometimes it's tough to comprehend in terms of can you actually deliver hospital level of care and SNF level of care inside the home? And yes, you can. We have our first couple insurance contracts in Denver, which we will start next week on Wednesday to determine, do they actually meet admission criteria? And we will deploy a brand new team that is serviced by Dispatch Health to deliver hospital level of care inside the home.

I want to talk a little bit, how we got to this. There are programs across the country, in little pockets, that deliver hospital level of care in the home. And it actually started back in the mid-nineties with a gentleman named Dr. Bruce Leff, a geriatrician out of Johns Hopkins who started this and validated through some studies that care could be delivered very safely in the home. And he actually coined a term in an article, “Hospital Home” is the next

blockbuster drug. If we can actually deliver 5 percent of admissions, typical admissions, inside the home, you would save billions of dollars to be able to do that.

Looking at our data, when you think about the 32,000 patients that we treated last year, about 6 percent of those individuals that we get on scene, and work them up, evaluate them, perform some diagnostics—they were actually sicker than we initially intended, and we actually needed to send them to the emergency department appropriately.

When we looked at that 6 percent of data and evaluated their community medical record, 75 percent of those individuals actually were admitted to the hospital. So we said to ourselves, I think we have an opportunity to be able to admit those individuals from an ER team to a Dispatch Health hospitalist team and take care of them inside the home.

We will have hospitalists that are transitioning from our acute care team to our, what we call Dispatch Health Advanced Care inside the home, and we'll manage them for DRGs that consist of pneumonia, CHF, COPD, cellulitis, complicated UTI, electrolyte imbalance, and provide that same level of care with bedside nursing, with imaging, with pharmacy, with DME, oxygen, inside the home over the course of that two to five days, and then transition them for 30 days afterwards back into their primary care physician.

So that's what's next for us. We'll pilot this and run this in Denver. We have a lot of interest from systems and payers to scale this very, very quickly. But we're going to concentrate on delivering great clinical outcomes and great value with this level of care, as well. So that's a little bit about Dispatch Health.

Ann Elkins: Thank you. That was amazing. So innovative and incredible what you're doing. I'm going to start with a quick question for you. It's incredible that you've been so well received by the payer community. How have you been received by the more traditional provider organizations that you are transitioning patients back to, for their primary care?

Kevin Riddleberger: The initial reaction, to be perfectly honest with you, from primary care physicians is resistance—that feeling that we will actually be stealing patients away from them. But as you think it through and talk with them and go through the model and develop that trust from them, it ends up being an amazing partnership. Because they are being tasked with more and more, they are being tasked with being able to take care of a population in a more cost effective manner.

We really want to be a new tool in their toolbox that they could be leveraging. And that could be, use cases of trying to get a patient in that same day. We're now an option to really be their eyes and ears and lay hands on the patient inside the home and really tele-present back to them, “Hey, this is what we're seeing.” When I was taking call and when I was seeing patients, you get a call at three o'clock on a patient and what are your options? You're only going to get so much of the story over the phone. And we tend to be risk averse and we usually will send that patient to the emergency department. But now we're an option to be flexed in, to be deployed and take care of those patients in the home and have them follow up with that same primary care physician a few days later.

So we have grown those partnerships with health systems. We're now partnered with seven large health systems across the country to really help them be more effective in the shift from fee for service to value based care. As they're taking on more and more risk with payer partners and with the government, they are leveraging us to be helping them take care of those patients in a different manner.

Audience member: You've talked a lot about your average age being 68 and being approved by payers, but a lot of CMS focus there. You have a patient base, though, that is working-age and with children. You talked about suturing kids and such. So do you have relationships with payers for their employer sponsored—insurance base, not their Medicare base?

Kevin Riddleberger: Yes. It depends on the line of business, on the commercial line of business or some of their self-insured clients. Brokers use this a great deal out in the marketplace to be an alternative, as they are selling their products and services out there, as a convenience play, more of a comfort play of delivering that care inside the home. Many times I'll get texts from friends and colleagues around, “We were just in an HR benefits meeting and Dispatch Health was highlighted.” So we do work very closely with the commercial payers as being an option for their employer populations.

Audience member: You mentioned the average call is about two hours until you're in the home, and then you talked about suturing a child. So is there some sort of prioritization so that the kid's not bleeding for the two hours until they get there?

Kevin Riddleberger: Yes. You're on the phone with them the minute they call, or within two minutes of when they request care via the mobile app. And so, during that risk stratification process, that feeds into our logistics platform to understand, how do we look at the clinical acuity of these patients, and to be

able to discuss and give some pointers to that family as they're going through that episode. And that could be a laceration or that could be an individual having some shortness of breath, so it's really making sure that we're giving them some insight around what to expect during those two hours to be able to provide them some comfort there.

Audience member: How does a patient know to call you guys and that it's a covered benefit as opposed to getting in the car and driving to urgent care, ER?

Kevin Riddleberger: That's been one of the—I don't want to say challenge—but when you develop a brand new type of service that really does not exist in markets, we're continuing to do that over and over again as we've expanded over the last few years. It helps a great deal, and where we see a lot of our patients is, coming through our clinical partners. So when we go into a new market, we usually will have a health system partner. And those health systems, whether it's their primary care physicians or specialists or home health agencies, they are trained as to when it is clinically appropriate, and develop workflows with them to be able to leverage our service.

And during that time, you start to gain some adoption of the service. At the same time, you're developing some tactics on marketing techniques out into the general community, regarding the service, as to when they could be calling us versus going to the emergency department.

The three most common things that we get are, one, it looks super expensive and making sure that we develop some trust around that cost and provide some transparency there. The other piece questioned by consumers is really what level of care could you provide safely inside the home, and making them understand what all we bring, and the clinicians that are actually coming to the home to be able to take care of them. And that just takes some time, the right messaging and the right partners in those communities.

Audience member: Do you guys provide any mental health services during those calls? And if not, do you plan to?

Kevin Riddleberger: The primary care physician is maybe the first, most common question that we get. Mental health is probably a very close second. There is, as we all know, a big epidemic or issue around access to mental health providers. We do not provide standard mental health inside the home. We screen for mental health upfront to make sure that the patient is safe. We want to make sure our providers are safe inside the home. If you look at some of our markets that we serve, there are some pretty rough areas that we operate in, and we want to make sure, first and foremost, the patients are

safe and that our clinicians are safe. But our clinicians are also providers that either also work in the ER or they've worked for five, 10 years in the ER; and they're very, very comfortable treating those individuals that are coming to the ER with mental health disorders and to be able to acutely take care of them. The challenges, then, are making sure that we coordinate with mental health providers afterwards. It's something we're continuing to explore because it's such a need and such a big, you know, opportunity out there. But for right now, we're working the best as we can with community providers to be able to get them resources after we encounter them in the home.

Audience member: Is the scale one of the first pieces of equipment you take out of your car and bring into the home? (laughter)

Kevin Riddleberger: We do have scales, and they are important, but it's not a requirement that we obtain a weight. We'll obtain a weight when it's clinically relevant to obtain a weight. So if we're seeing a patient that's transitioning from the hospital with new onset of CHF, and we're intervening on that patient, we want to make sure, check a weight when they're in the hospital and check a weight when we're seeing them in the home. But we don't check weight on every patient.

Audience member: Sounds like an appropriate use of the scale.

Audience member: So, first of all, congratulations; I mean, I'm really excited. This disruption that we're seeing in the way care delivery is, is really necessary for our industry. We need to transform, we need to be future-forward and focused on where those innovative changes are. And it looks like you're definitely the three aims. Your triple aim really gives you a focus of where you're making those changes; one around consumers; one around the lowering of the cost, which impacts consumers, payers and providers; and the third around, making that integrated care, which also supports the payers and the providers. But if you look at those three aims that you have, which one is really sort of the true north for innovation for Dispatch Health? Is there one of those that you kind of ladder to? Is consumerism driving the future or is it really to create a better integrated health system? Can you categorize one of those as the true north?

Kevin Riddleberger: I would say it would be nice to be able to—and this is the decision that we made early on—continue to demonstrate as much value as possible. Now, how do you define value? That value could be consumerism, where we deliver an amazing service, to young families that would like care delivered to the home. Or we could focus on individuals that truly we're removing from the emergency department; that we are going to

deliver great clinical care and move the needle on the savings side of things. We chose—really, all—but if you had to pick a true north, it's that high acuity, high social need patient.

We want to make sure that we're working with our partners, again across the continuum and working with our payer partners to say, "Hey, these are the individuals that we want to intervene on, where we're going to produce the most value for the system." We probably don't provide that much value when we're going out to the home for an individual with a kid with otitis media, an ear infection or a sore throat, or I'll call it a man cold—that's not going to move the needle in terms of where health care needs to go. There are resources available for them—urgent care, telemedicine, and first and foremost, there's great primary care physicians available to be able to take care of them. We want to really be focused on those individuals that would be going to the emergency department, and we're an alternative to them to provide that 8 to 10X return on the savings for that patient.

Audience member: When you talk about treating patients with chronic conditions, do you have patients that you see on a regular basis, or not necessarily? Is it always in a sort of an emergency situation?

Kevin Riddleberger: We do schedule visits with health system partners for individuals that are high risk for readmission, individuals that are in the hospital. They may have what's called a "high LACE score" or a score that determines that they're highly likely to bounce back to the emergency or bounce back to the ER or the hospital. So we will schedule a visit for them 24 to 72 hours after they transition out of the hospital. It also could be because they don't have an appointment with their primary care physician for another 10 days or so, and so we are seeing those individuals on a prescriptive manner, but we are not managing patients for their chronic disease.

Now, these are individuals, the typical patient, we talk about that 68-year old average age. On average, our patients are on 10 to 12 medications. They are suffering from four to six comorbidities, on average. So these are sick, sick patients, and they have a lot of acute or chronic problems. But we're not managing their diabetes, we're not managing their hypertension for them.

Ann Elkins: Thank you so much—this was fascinating.

Kevin Riddleberger: Thank you.