



# AHA Webinar

## Innovation and practicality drive the future of virtual care

**Host:** Ladies and gentlemen, we now have our presenters in conference. Please be aware that each of your lines is in a listen-only mode. You may submit your questions electronically any time using the Q&A pod located to the left of your webinar platform. You may also download a copy of today's presentation, using the Resources pod located below the Q&A pod. It is now my pleasure to introduce today's first presenter, AHA Moderator, Monique Showalter. Please go ahead.

**Monique Showalter:** Thank you so much, Stephanie. And welcome, everyone, today to our first webinar, and we are delighted to be hosting so many of you. All of us here at AHA hope you are safe and well. And thank you all for your organizations' service and dedication to the patients of your communities. AHA is pleased to be hosting today's webinar entitled, "Innovation and Practicality Drives the Future of Virtual Care," featuring the Froedtert and the Medical College of Wisconsin Health Network, which will share the best practices of its evolving virtual care experience. This webinar is brought to you through the generous support of Accenture. Today, we'll hear

how the Froedtert and the Medical College of Wisconsin Health Network, like many health systems, hospitals and provider organizations, relied on virtual care to respond to COVID-19. In this webinar, we'll hear details of Froedtert and MCW Health Network's experience, as well as Accenture's observations from several other health systems, providing insights on how hospitals can successfully transform use of virtual care to provide better care more effectively. Today's discussion will include how using virtual care has brought together patients, families, specialists, health professionals and other professionals, including translators, into a dynamic, coordinated virtual experience versus the traditional one-on-one virtual visit. We'll also hear how patients facing complex conditions will use extended virtual visits, significantly exceeding the typical 10-minute urgent care visit. Virtual care will use timely workflow and patient data to enrich the support patients and families receive during a virtual visit. We'll also hear how scalable enterprise technologies expand virtual care options, while also capturing real time data to support analysis of interactions and providing payment

documentation. Note, too, that we've allowed time for your questions. We've already received several questions which our speakers will address as time allows. If you wish to download the presentation at any point, you can easily do so through the Resource section of your screen. Today's event is being recorded, and the replay link will be sent to all registrants and attendees shortly after today's event. So, let me briefly introduce today's speakers.

I'm thrilled to introduce one of three outstanding presenters for today's event. Mike Anderes is the Chief Digital Officer for Froedtert Health and President of Inception Health, a company formed by the Froedtert and the Medical College of Wisconsin Health Network to accelerate the adoption of digital health, identify and partner with innovative companies, and increase the innovation and capacity of the network. In his role, Mike leads teams that provide 24/7 remote monitoring and intervention, software engineering for the enterprises' digital engagement platforms, digital transformation project management and corporate venture investing in digital technology companies. Mike's certainly busy. Mike is a Fellow of the American College of Healthcare Execs and received a Bachelor of Science and Physical Therapy from the University of Connecticut, as well as a Masters Degree in Business Administration from the University of Arizona.

Thanks so much, Mike, for participating in today's discussion and sharing your success with our listeners. We're also being joined by Mr. Greg Smith of Accenture. Greg has more than 25 years of creating value across provider, payer and life science companies. He currently leads the telemedicine and virtual health offering for Accenture's health practice. Greg has worked and supported telemedicine programs internationally, including within Saudi Arabia, as well as throughout the U.S. Previously, Greg provided telemedicine direction to a variety of providers, payers and life science companies, as well as to the Veterans Administration, state hospital associations and the departments of health. Last, but certainly not least, is Dr. Darryl Gibbings-Isaac. Darryl is the Senior Manager in Accenture's Health Strategy practice. A physician by background, Darryl has extensive experience in growth strategy, transformation, consumerism and innovation in healthcare industries. Darryl was most recently Clinical Director at Babylon Health, a telemedicine primary care provider leveraging artificial intelligence. And his previous professional experience includes being a practicing physician in the NHS in England. Welcome, Mike, and thank you so much for your participation, Mike, Greg and Darryl. It's now my pleasure to turn the floor over to Greg Smith to begin today's presentation. Greg, the podium is yours.

**Greg Smith:** Thank you very much, Monique. First of all, before we get into what we're going to talk about, Monique, thank you very much and the American Hospital Association for giving us this opportunity. The key to today is to hear less from Greg and more from Mike and Darryl. And so, let me talk to you a little bit about what we're trying to accomplish today. Froedtert is one of the more interesting environments in which they made a commitment to virtual care several years ago. That made it possible for them to address the unique demands and needs of COVID, much more easily than we found for other health systems around the country. And so, part of today's conversation is to hear from Froedtert and from Mike about that experience, but at the same time, we'd like to set up a panel discussion between Mike and Darryl to discuss both their experiences in context. We'd like to walk through the journey of where virtual care is, how it responded to COVID, what we found to be successful and measurable, and what the outcomes were. Then we'll talk about where we see people going next, where Froedtert is going next, and where others are going, what their scalable technologies are, what are they going to scale, what role innovation plays and what their journey to get there looks like. And so, in a minute, I'm going to turn it over to Mike, and so that he can give us background about Froedtert and all of the work they've done over the last several years. But I want you to draw a line underneath that top bullet on the right hand side.

That's where we want to open it up for discussions and questions. It will be a panel discussion, so there will be many opportunities for you to ask your questions and contribute to the discussion. We've received several questions from people in the audience, and folks in the audience, I know several of you. Thank you very much for attending. It's good to see you again. Please contribute your questions as we go through, and we will work to not only answer those questions that have already been provided, but we'll try to answer all of the questions as we go along. So, I think as we do this, if you think about this more as a panel discussion, more back and forth, I think we'll get a lot more out of it. So, the first thing I'm going to do though, is turn it over to Mike and have him give us some background and details about Froedtert, how they uniquely made use of virtual care, and how they were able to respond to COVID.

**Mike Anderes:** Thanks, Greg. It's great to be with you today. Hopefully, what we present today will be helpful in some cases. We're definitely not suggesting we hold all the answers. In fact, you might see some things we've done that you could give us tips on how to improve. This first slide is an interesting example of where we're going to make a point and maybe deviate from the common interpretation of what virtual care is. You know, this is the image you see on websites, reports, other things. It tends to show a video conferencing session between a patient and a provider.

Our perspective is that this is just the tip of the iceberg when it comes to how virtual care can actually change how care is delivered. Keep that in the back of your mind as we go through this. If you don't have much knowledge of Froedtert, we're a middle-sized organization. We're definitely not as big as some of the bigger brand names nationally, but based on our size and our vision, we've taken some steps that I think have been unique in the industry. We are based in Wisconsin. Wisconsin is a pretty competitive state. It has some high performing organizations in it. We are academic at our core, but we'd argue our organization is a more vertically integrated academic health system than others, where we have a health plan, a third-party administration company that we own, and a lot of ancillary businesses that we own that are subsidiaries, even extending into the post-acute space. The one separate LLC that we own, called Inception Health, may be relevant for this discussion. It was founded about six years ago and was our attempt to drive a digital transformation through the organization through this separate but connected organization. Some of the work you'll see that we've accomplished did come from that initial investment. That's Froedtert in a nutshell.

I'd like to start my discussion on virtual care by giving credit to our partners at Children's Wisconsin. What you see on the screen is 365 days, so 365 dots here, which represent one individual patient or community member that you serve.

Typically, our organizations, especially with a healthy person, might have an extremely limited understanding of what that individual is up against in terms of health. You might see them once a year for some episodic care, and then maybe once for a preplanned annual checkup. In reality, that person had a whole bunch of other life events going on related to their health. And in a virtual world, these are all opportunities for engagement. This is a simple example of a healthy 35-year-old. If you were to take a look at maybe one of the more common people who intersect with our organizations, say a 65-year-old with type 2 diabetes, this gets more interesting, because in a typical environment, you might see that person four times a year, and maybe have a few ancillary visits with that individual. But this person also has day-to-day needs and day-to-day health-related questions that they might go to Google for as they attempt to change their health based on behaviors. Perhaps I see data that suggest they're not doing well from a diabetes perspective. The question we want to pose, which I think is where we tried to take this virtual care technology a few years ago, is do we really want to engage with somebody 365 days out of the year, and power it with virtual solutions? That same 65 year old in the future might see something a little bit more like this, where you have somebody who's responsible for care coordination engaging with them throughout the year, and maybe some of those visits turn into asynchronous e-visits or a video visit.

If the person has their own questions, he or she might use a virtual triage self-service tool. And if we do identify some patterns of poor health or poor data, we might put him or her on a remote monitoring platform and start to prescribe a digital therapeutic to help them self-manage their condition. It creates this much more integrated experience for this individual: you see that the visits are actually the same, but the touchpoints could be 150 or 200 a year. It really changes the perspective.

How will you “bucket” this work in virtual health within these five categories? First and foremost, is in patient self-service. We think this is the one that's going to scale the most in the future and from the economic perspective is going to allow us to have a sustainable model. Clearly, there are still going to be visits, but if you look at what's wrapped around those visits, or what takes their place, you have digital therapies, which we would argue are becoming better and better every day. And remote monitoring—something of an overlap with digital therapies—can be distinct. Then finally, you have care coordination for select groups of patients that we serve, which has always been virtual. These are our five categories. What I want to share is what we experienced over the last year, especially with COVID, regarding each of these. I'd like to tell a little bit of a story regarding some of the data we saw or some of the key questions that we had to address in watching these trends.

Let's start with patient self-service. This is, again, the one we think has the most potential to scale. We definitely found that our community would engage with virtual triage, especially with COVID. We had a whole lot of self-service, self-triage episodes that led people to, "here's the next step for you." With COVID, a fair amount of the concern was, "do I need a test, and how do I get a test?" Our system was positioned well, because our lab has a capacity to do nearly a quarter of all the tests in Wisconsin by itself. To give people access to it, we turned to these asynchronous e-visits to get people to determine if they're qualified for a test and then issued a ticket for a test and booked them into a slot. Approximately 37,000 people from September through December went through that process. It wasn't even a full year, but we saw quite a lot of uptake. The thing I also don't want to minimize here, because this has also been going on either through the telephone before EMRs and now through portal messages, is that a lot of care takes place outside of the visit that is already virtual, whether it involved calling the doctor's office in the past or now sending a portal message. Some say portal messages are on track to be almost on parity with the number of visits that we do in person. This is a lot of work for in-care teams to manage that is already virtual. And so, when you look at patient self-service with an eye toward scaling these things, you have to think, are you going to have a centralized scheme to do this?

For us, we're pushing toward centralization as much as we can to try to take some of the day-to-day challenges off our front lines. Some of this will remain decentralized, especially from the portal messages, and will probably continue to be managed via the local care teams. But we want to try to centralize this work. So, if we move from patient self-service to go to the topic that I think everybody is interested in: the impact of the pandemic. With COVID, these are the types of statistics that they like to cite: "we did 'X' number of hundreds of thousands of video visits," or, "we saw 'X' percent of our visits convert to virtual." I want to minimize this in terms of its importance. It was the ability to deliver care, where otherwise it may not have been safe to deliver care. So, it's still important, but I would keep encouraging everyone to not think of visits as the be-all, end-all for virtual care.

Consequently, we "reapproached" it. Our goal was to scale up what we already built, pre-COVID. We did extend it to care team members that would have one-on-one patient interactions, and that went into PT/OT [physical therapy, occupational therapy], pharmacy and beyond. We didn't look at this as just sort of a pure physician or APP tool, but really as a broad care delivery modality. We would argue almost all of these are decentralized. They are listed as you visit with your "fill in the blank" provider. With each section of our on-demand video visits, we stood up our own internal model essentially right at the

beginning of the pandemic to allow people to be assessed for COVID and order a test if they needed it. And it took off. We went from a few hundred of these a month to thousands and thousands a month, because, again, it was a centralized, easy-to-access service that was basically on demand. The interesting statistics, when we look back on 2020, is that even though we're an academic medical center and heavily skewed toward specialty care, we still, over the entire year, saw about 20 percent of all of our visits were virtual. That included even the pre-pandemic months. Obviously, our highest level was somewhere around 75 or 80 percent of all visits being virtual during the pandemic's peak, and like most of the rest of the country, we have seen that erode over the rest of the year. The other important statistic that we've learned, because as we've done some of our analysis, is that many new people came to our system because they actually want a virtual option that they could use. About 25 percent of all new patients that hit our health system in 2020 came through a virtual channel. It's definitely something that I think of as a requirement now.

If we move into digital therapeutics, this is an area that Froedtert and the Medical College have been very bullish about over the last five to six years. We've been at the forefront of this trend, coining the term "digital therapy formulary" for our system. We can now prescribe digital care for more than 35 conditions. You can see most of them up here, and they range from chronic

disease tools to episodic care health pathway tools, but in many of these cases, the attempt is to give people a platform or way to manage their condition through education and whatever behavioral cues are built into these tools on their own. We will only escalate cases to our care team when there's something flagged as needing intervention. These are the tools that we use that connect with every one of those dots on that 365-dot map. For scale purposes, we've centralized most of these. The care team that manages the back end of most of these prescribed digital therapies is a centralized team in most cases, because that is really the only way we can see of scaling our service to delivery. In 2020, we saw quite a significant uptick. You know, we do invite people to participate in these tools at a rate in excess of 25,000 individuals, and we did actually have 25,000 people sign up and go through these care plans and engage with these tools, which for us was definitely a record year. Slightly related but different is remote monitoring. And while some digital therapies do have a remote monitoring component to them, we also look at this as a separate way to engage patients. It's typically episodic. The big uptick we saw in this was COVID. And the kind of cool story we had at Froedtert was from very, very early days, so this would be in early March, if you were to have a COVID test with Froedtert, and have a positive result, we created a care package for you. We called it a COVID care kit. And in it were a pulse oximeter, instructions to become engaged with our digital

remote monitoring, a phone number to our 24/7 virtual care team, so if you ever had any problems, you could call 24/7, and a number of other educational pieces of material to help you manage yourself at home. We eventually migrated that to just shipping you that kit the moment you had a positive test. We were able to get the kit to everyone who tested positive, usually in about 48 hours from that positive result. And then they could enroll immediately in remote monitoring.

Over the course of 2020—this program is still ongoing, so the numbers are still climbing, unfortunately—we did manage to treat 10,800 patients in their homes through this combination of pulse oximeter and the digital engagement tool that we use for these community members. We've had some amazing stories that came through that effort, which was a scary time. For people to have this lifeline to our teams on a 24/7 basis, went a long way. Monitoring, for us, is something that covers everything from the ICU all the way into the home, and so we leveraged this centralized virtual care team to monitor all those environments. Instead of asking different clinical areas or different parts of the organization to monitor certain specific parts of the care continuum, we just centralized it all. We don't view this as something that people get plugged into for life, but something that's more episodic in nature, so it might be until you get something under control, or until you meet some sort of milestones, and then that

remote monitoring is diminished. This is obviously a space that we believe will see a lot more applicability in the coming years, as things move more into the home and in the virtual care bucket that we would say is distinctive, this concept of care coordination, which I think almost every health system has. I don't know if they always think about it as virtual care, but this group here—looking at people more holistically, looking at them across the entire year or beyond—has also used a lot of technology in our organization. Historically, they used telephones, but now we've got a variety of automation tools that they can use to engage with patients, and basically scale their impact. And this group is something we think should also be centralized, because trying to do care coordination in different operational units of our organization was untenable. We centralized this, and it's been pretty effective. So that was the end of what I wanted to share just from our historic perspective. I'll pause here and see if Darryl wants to pick up.

**Greg Smith:** Darryl, do you have any thoughts about Mike's talk, especially in the areas that you want to highlight? Also, one of the questions from the audience talks about artificial intelligence (AI) and machine learning (ML). So, Mike and Darryl, I'm interested in your thoughts as to whether that's clearly an area, or whether there are other areas in the spaces that you just talked about, Mike, that AI and machine learning can play. First, Darryl, any thoughts?

**Darryl Gibbings-Isaac:** First of all, let me say what a remarkable journey Froedtert has undertaken. Very impressive. Not everyone has had that kind of starting point, so it's really great to hear it. Related to the AI and machine learning question, we have seen that deployed during COVID, partly on the kind of self-care piece that Mike was alluding to in order to expand capacity, given that all of the systems were overwhelmed by patients potentially coming in with COVID. It provides a way of identifying those who essentially were at risk of having COVID, giving them some information about what to do, thus de-stressing some of the systems and allowing them to keep functioning.

**Mike Anderes:** You definitely hit exactly on how we started. We think about it in terms of what process do we want to automate. That's our starting point, and the triage front-end space was where we thought AI could provide a lot of benefit. The tool that we use is on the spectrum of AI. I think of it in terms of, "is there something we want to automate, and is there a good tool out there to help us automate it?" And self-service and triaging were great places to start.

**Darryl Gibbings-Isaac:** Absolutely. Building on that, I think one of the elements that we've seen in the market is ensuring that there's enough trust in the AI from a patient or provider's perspective. That trust effectively enables triage and relieves capacity constraints. Without that trust, someone might go through an



AI-driven interaction, for example, but then still not believe the advice, and subsequently following through to interact with a person anyway. We want to avoid this double interaction, and I think over time, we're getting to a space where consumers are more comfortable with AI.

Mike has already given us some logic around virtual care and meeting the challenge from that perspective. I thought I'd shed some light on what else we've seen, and more importantly, across the market. It's quite safe to say that no system was entirely prepared for the impact of COVID-19 and the sheer strain it put on provider capacity, finances and the way that care was delivered, but this strain put on the system really spurred innovation across it. So, there was a large displacement of care and need and services outside of the traditional in-person channel, be it through safety and/or capacity issues, and most, if not all providers recognized that virtual care could help accommodate that displacement. That said, providers were at different starting points on their virtual care journeys, as Froedtert's story reveals, when this occurred.

Consequently, the degree to which virtual care initiatives can successfully address the COVID-19-driven issues vary in a similar way. For example, if we take the capacity issue, it means providing virtual care capacity across the system to meet the core for providing safe access to care. This happened rapidly.

From that standpoint, it was quite successful. But when you look back into the deployment of that capacity, there were certain variations, given the pace of rollout and with respect to starting points for each of the health systems. We've observed a huge spectrum that ranged from those who never had virtual care capacity and were essentially building it from scratch, to those who have so much virtual care capacity they've been selectively providing it to other systems for a number of years.

So specifically, to touch on three different spheres we observed in those groups. First, providers needed to understand which use cases were most amenable to virtual visits, to ensure that capacity was used appropriately and efficiently. As a result, some systems have mapped out patients, provider interactions, and where applications should include acute and post-acute settings—what would work or wouldn't. We've observed over 100 different use cases being deployed, and some of the broad themes that we've observed in those systems include clinical activities that can be performed at a distance, such as ongoing management of chronic diseases, pre- and post-procedures, etc.

Second, service lines with diseases where there's limited need for hands-on examinations—where you don't need to touch the patient, such as behavioral health.

Third, workforce management issues, which might include services where a shorter supply could benefit from other models. Another difference we've seen in the market involves operationalizing capacity with only minimal disruptions to patients and providers. Examples could include the degree to which technology and workflow integration actually occurs, or using virtual tests as protocols and procedures that are sensitive to both the different care setups and the care team members. Likewise, establishing training programs to achieve parity for the in-person experience. Let's round this out. Virtual visits among forecasting models, and the configuration of that supporting virtual workforce, which could be scaled up and scaled down as needed.

I think the final discussion to touch on, before I put the mic down, would be the financial sustainability of the capacity. So, not just the integration of the existing care model, but a redesign of the care model with virtual care as part of a broader consumer-driven approach, but in a way that is financially self-sustaining. We've seen some of this happen with most response systems that we've seen in the market. Back to you, Greg.

**Greg Smith:** Great. Mike, I'm curious: in your journey over the last five or so years, and not just in COVID, what has been the role of the clinicians within the organization, and how have you managed their input, the change taking place, how to redesign the care model, those kinds of things. How did you find success in those relationships?

**Mike Anderes:** That's a great question. The answer is we had to work with each of the service lines or product lines of the organizations to determine what essentially they thought they were going to be competing against, how their model had to change, and what menu of different virtual or digital tools they had available that could help. I think when they were involved with that selection process, there was a fair amount of adoption, because they had some say in how things would work. You can imagine—it's a very different question for an orthopedic surgeon to ask where they see their practice going and what the role of digital is compared with a primary care physician and whom they compete against. It's a nuanced discussion because there is no one size fits all for it. But that's how we approached it, using an outside-in approach to understand what you have to do to be competitive and showing what some of those new emerging competitors are trying to do, which in some cases are virtual. Then you must help them come up with a good plan to involve their practice.

**Greg Smith:** I'm assuming, because of all of that work you were able to respond to COVID in a much more proficient way than many others. You didn't have to scramble for a bunch of new technologies as we saw in many other places. We have an interesting question: who's responsible for preparing the workforce to do virtual care at Froedtert?

**Mike Anderes:** It's a team effort. We have physician leadership, who I lead from a sponsorship standpoint. We also have typical training resources that may have originally been devoted to EMR training, for example, which we can deploy for "at-the-elbow" support. And then, we have a broader organizational development department helping with some of the change in the management aspects of this. There is no single individual that's responsible for this change, because while it's one thing to know the technology, it's another thing to actually say, "I want to use it." If organizations don't address the broader, "why would I want to use this" question, all the training in the world on how to use it is pointless.

**Greg Smith:** I've been at this now for over 30 years. About five years ago, we had an opportunity to work with one of the premiere organizations doing virtual care. And they were looking to go commercial. One of the most eye-opening experiences in that discussion was the recognition and need for change management. You can say, "yes, you have clinical; yes, you have technical," but if you don't bring in change management expertise and capabilities, and surround that whole team with this attempt to get people ready for virtual care, you will find places where it doesn't work as well. We have another question, which is the reimbursement question. However, Mike, I want to return to an earlier question that was also asked.

When you were speaking of virtual visits, and I'm going to pull up the slide, you talked about the fact that you did them in multiple modes, modalities. Do you have any sense that, of those modalities, what the proportion was? What was more and what was less during the adaptive period?

**Mike Anderes:** We have data you wouldn't believe. But, even though you can't see that picture very well, that is the accurate interpretation picture of all our volumes by week through COVID and by modality. So, the gray is in-person. The pink is by telephone. And you see early on, it's crisis mode. People weren't ready to schedule video visits, so they were using telephone more heavily, and then it gradually moved more towards video, which is the darker purple color. What we have found, though, with some of the populations that we serve that lack access to bandwidth and to our smart phone net, actually cannot handle our video visits. That's a barrier. That's why we've kept telephone as an option for care, mainly out of a need to meet all populations with virtual access. In the early days we attempted to encourage video over everything else, because of the belief that the quality of the interaction is better. And while we still believe the quality of the interaction is better when you can see somebody, but we didn't want to completely eliminate the telephone. That's the breakdown. Right now, about a fifth of all our virtual visits are by telephone, and then the other four-fifths are video.

**Greg Smith:** That's great, Mike. And, take a look: The American Journal of Managed Care in January 2021 had a very interesting study with some great details on telephone versus other options. They found it was about an equal mix in the early period of COVID activity. The fun thing about it is they also say who was using the telephone, and who was using video. What did they do in the case of low bandwidth kinds of activities? It's a relatively new study that's out there, that I think answers some of those questions. Mike, let me come back to you and ask the question about some of the measurable successes. I always find if I'm going to go talk to the rest of my organization, the more I can talk about something tangible and measurable, the more persuasive I can be. Can you give us a sense as to where Froedtert has seen measurable successes and tangible benefits?

**Mike Anderes:** I think you saw it a little bit earlier, but we pretty rapidly got back to parity with what our pre-pandemic volumes were. When you look at our graphs, the fact that we rebounded to 100 percent of our pre-pandemic volumes is a pretty good outcome. I mean, it's one of the probably ultimate outcomes. If you look at some of the other things that are more process driven, we were able to serve an immense number of people without adding FTEs, especially with anything like COVID. We would normally try to monitor 10,800 people at their homes. We were able deal with essentially 1.5 nurses per shift.

Likewise, getting 37,000 COVID tests and scheduling people for them would normally have taken a pretty significant call center to accomplish. We were able to do it with basically one provider managing through an asynchronous process. When you back into how we actually achieved it from a workforce perspective, some of the outcomes like the value delivered per dollar that we put into it were pretty substantial.

We're still shifting through the clinical quality metrics, so one question would be, if we're monitoring and engaging people with their mental health concerns or with their diabetes remotely, did we see any drop-off? Overall quality scores are A1 in most of it. We don't have all the data in yet, but our belief is that we actually didn't miss much of a beat when it came to the actual quality metrics, even though we shifted a whole bunch of care to the home. When we think about homes, those are the kinds of buckets that we would look at. That's our growth cost of care and then clinical outcomes, and those all seem to do alright. And then, the last was our patient satisfaction data. We measured incessantly during this period to see what people felt about virtual care. Were they finding things either helpful or not helpful? We iterated quite a bit during that period. But our virtual patient satisfaction scores were on par or better than what we had for in-person care, and we're already a top performer in patient satisfaction. So those are good for outcomes and metrics over that period of time.

**Greg Smith:** At any point in the COVID crisis did you see a dip in those scores, or were they fairly consistent and equal to what in-patient was throughout?

**Mike Anderes:** The one time we saw a dip wasn't in the overall satisfaction, but in the sub-metric around how easy was it. When we forced everyone, including the laggards and the people who never wanted to do this into that mode, I think there were people who struggled with some of the technology. However, when they give us feedback, they never suggested that their overall satisfaction was lower. I think they were thankful that we were able to offer something, even though it was technically challenging for them. It actually migrated back to the notion that you get to choose your path. If you want to do it virtually, you can. If you want to come in person, that's fine, too.

**Greg Smith:** So desperation breeds a little bit of tolerance when it's all said and done.

**Mike Anderes:** It does. It absolutely does.

**Greg Smith:** That's good. Darryl, I know that we've talked to some who had other issues. Do you want to highlight any of the other issues that we've seen in other health systems. They're now trying to get their hands on the things that made it difficult to either measure success or get a handle on the success they were having?

**Darryl Gibbings-Isaac:** I think one of the challenges involves the value piece. It's one of the most nebulous measures. It's been one of the most challenging, and part of the challenge is that we've not really had a long time period to truly connect virtual visits to end outcomes. But equally, the mechanisms to measure virtual care outcomes are pretty immature. For example, how do you know the virtual visit appropriately replaced or delayed the need for in-person care for that issue? Did it add an inappropriate visit without adding value? And we're seeing some systems try to address that insight through the main patient surveys after the visit, to get a proxy for the issue resolution or outcome in that sense. And we're also seeing post analysis of more longitudinal care journeys from the impact on appropriate utilization and systems. Also, where cost accounting exists, you might look at the economic impact, too. And again, I think it's been pretty early days for most in terms of navigating that.

**Greg Smith:** I know in several places that we've talked about, because there was such a rush to meet the demand, they found that they really didn't have appropriate tracking information. There was a very interesting article that came out in Health Affairs that looked at claims and provided some very great insights in terms of what took place. One of their basic theories was that there wasn't as much activity as we thought there would be, and what we found is that so many of our clients and the companies we worked with

struggled to capture what was taking place. They had a hard time transitioning to making sure there were appropriate claims filed and everything else like that. Mike, I'm assuming that on the back side of the organization, you did not have those same struggles, or were able to resolve those struggles fairly quickly.

**Mike Anderes:** It was dynamic. We were getting different guidance on a pretty regular basis about what payers would pay or not pay, and how to code things. But the team was quite flexible. We did hold back a lot of claims until we had more clear guidance about how these payers wanted to manage them. I don't live in that world, so I don't know exactly all the consternation they went through, but I do know it was a dynamic time, and the group definitely had to flex a few times, more so than usual.

**Greg Smith:** Great. We have about eight or nine minutes left. I've promised a couple of other people we'll get to their reimbursement questions. And so, we're going to save it for last. Before we do that, Mike, one of the things Froedtert is known for is innovation. I'm interested in what you think the role of innovation has been in virtual care at Froedtert, and then, Darryl, I'd be curious what you're seeing others doing similarly? Mike?

**Mike Anderes:** It's a good question. I think on one hand, an academic medical center should be innovating, just because it's kind of in the DNA. But I think if you're targeting virtual

care, I'd say it was that investment in Inception Health. Basically, that investment laid the groundwork for this pre-pandemic, as did the toolkit that we went to that consists of different modalities and options in that very challenging time where we had to ramp things up very quickly. If you have an innovation mindset, you've probably gone through some forms of rapid iteration instead of that overall kind of mindset. You're comfortable with things not being perfect out of the gate and then iterating. I frankly think that what the pandemic did for most health systems was force them to be innovative; force them to go into that rapid iteration mode where they typically have not been comfortable. I think we had a little bit more of that baked in because of who we are, and then the investment in digital and inception health going back five years before the pandemic.

**Greg Smith:** Darryl, any other thoughts around innovation and where we're seeing it?

**Darryl Gibbings-Isaac:** We've seen quite extensive innovation in the virtual care space, so I'll just touch on innovation around a couple of things. One is around the Cary Virtual Visit Interaction, and the other is probably the virtual interaction itself. Let's talk about the Cary Virtual Visit Interaction, which includes everything that's happening around the virtual visit. It's currently recognized that the video visit by itself is somewhat limited, but linked adoption provides a momentum that reaches more with the actual visit

by bringing more modalities into the visit itself. This might mean more actual health visits from the patient end involving vital signs, imaging, point of care testing, direct observation of the home environment as it relates to SDOH, third party physical examinations, and wearables. But the other broad theme for the Cary Virtual Visit Interaction is integrating touchpoints after the visit, so the actions can be triggered to further facilitate care management. For example, connecting the virtual counter to at-home blood draw services or medication home delivery services or even connecting the patient to that next point of care through integrated bright, shiny apps.

The second thing I wanted to talk around is the virtual visit itself. There has been a movement of the visit from its historically centric and rigid form, which was mainly applied to simple cases such as urgent care, to something more multi-modal, where there's a dedicated patient virtual waiting room. While the patient waits, he or she can access digital content, for example, educational materials that cover their reason for the visit, perhaps, or medication guides, or they can even interact with chat box to handle administrative issues, and so forth. That shift has allowed a multidisciplinary team approach, and applications for more complex and longitudinal care cases, which means that virtual care can progress from providing convenience at a distance to managing complexities at a distance. And that, of course, opens up more use cases. Feel free to add to that, Greg.

**Greg Smith:** That's great. I do want to tackle the reimbursement question. Mike, first thoughts on where we think payers are going to go in terms of payment for virtual care, where do we think CMS is going to go? Any thoughts on reimbursement?

**Mike Anderes:** I'm not an expert in this space, but I think our view right now is it's unknown why you're using virtual. So if you're using virtual, it's part of primary care, and you're using it in a way where maybe it isn't the center of your strategy. You're hopefully in a risk-based contract at that point. Or you have to figure how you're going to take on risk, because these broader use cases involving remote monitoring or digital therapeutics really only work if you have some form of risk—not all, but the vast majority. And the rest, I think, we're of a mindset that this should be at parity with in-person. We know that not all consumers feel that it's the same, and they think it should cost less. We're not necessarily aligned there, but we're going to take it as it comes. In the end, we're not going to change a decision about whether a visit should be in person or virtual, based on how much we get paid for it. It's something we're going to try to manage just within our own top structure.

**Greg Smith:** I think we agree very much with what you're saying, Mike. Again, I'm anxious for more people to work their way to a more value-based, risk-adjusted understanding. In those places in which it's fee for service, I think we see a couple things.

I am not surprised that there is now a move to bring back some of the things, like prior relationships, for reimbursement. And I know there are organizations in the U.S. that are upset that that happened. But if you think about it from a commonsense standpoint, there's a rationale behind that. I do think as we expand the types of visits that we do, and deal with more complex sort of visits, then you see where there's opportunity to demonstrate even greater value and maybe get to different rate structures based around that. But Darryl, any other thoughts around reimbursement?

**Darryl Gibbings-Isaac:** The only other thing I would add is that the payer is clearly seeing the value of virtual care more broadly. We've seen in the rates of acquisitions and partnerships, such as Cigna acquiring MD Live, and the close ties between CVS/Aetna and Teladoc and others. Essentially, once you've got that value proposition on the payer's side, you're likely to see incentives which encourage virtual health on the other side. And that clearly requires something which is dramatically below parity.

**Greg Smith:** Mike, I appreciated your examples and use cases. I loved the one around remote patient monitoring and care coordination, because again, those have been opportunities for people to look to offer the service in which there are opportunities to get reimbursed.

And so, again, the fact that you have been successful at that, and it appears as if there's a clear need for that, I think it creates an opportunity for people to find services for which maybe the reimbursement is there. Monique, I need to hand this back to you.

**Monique Showalter:** Thank you so much, Greg, and certainly the speakers, Mike and Darryl, for sharing so many valuable insights on the topic of virtual care, which, as we've seen, has certainly increased in value and adoption throughout the past year, year and a half. So that concludes the time we have available for today's session. Shortly all attendees will receive an email with the link to the webinar session replay on the presentation. We certainly welcome you sharing that with others in your organizations. On behalf of the American Hospital Association, thank you so much to our attendees for making the time to listen in to today's webinar, and certainly a very sincere thank you to our sponsor, Accenture, and for our very informative speakers. That concludes today's program. Have a wonderful afternoon, and please stay safe. Thank you.