

NAADAC
ADVANCES IN TECHNOLOGY IN THE ADDICTION PROFESSION
PART VII: ADDICTION TREATMENT - A VIRTUAL FRONTIER
SEPTEMBER 10, 2021

CAPTIONING PROVIDED BY:
CAPTIONACCESS
contact@captionaccess.com
www.captionaccess.com

* * * * *

This is being provided in a rough-draft format. Communication Access Realtime Translation (CART) is provided in order to facilitate communication accessibility and may not be a totally verbatim record of the proceedings.

>>JESSIE O'BRIEN: The Q&A box is where you can put any questions you have for us at NAADAC or any questions for our presenters. At the end of our presentation today we will have a live Q&A where we will go through these questions. One of the great features about the community box is you can up vote in the questions you see that you would like to have answered which is great because it self-curates, so we can answer the questions you must want to see answered. Don't worry if we don't get to all the questions today, we will email the questions to our presenters and give them the opportunity to respond. And we can post them on the webpage where you registered for this webinar. As you probably know now, every NAADAC webinar has its own webpage that houses everything you need to know about that particular event.

Immediately following the online event, you will find the CE link on the exact same link you used to register for this webinar. For this one you can see the website at the top of the screen there,

NAADAC.org/technology/2021... There's also an instructional guide that will be useful as well to guide you through the CE claim process. If you haven't done that with us before, make sure to follow that. It's an easy to follow guide and you can get your certificate easily. Please note if you need more significant to say "live click on it please make sure to complete the CE quiz within the next 24 hours. Let me introduce you to today's presenter Thomas Britton, throughout his career he has -- Dr. Britton -- currently, Dr. Britton as President and CEO of the nation's largest nonprofit of substance abuse treatment, Gateway Foundation. He has taught and lectured across the country and is considered an expert in -- Personally, Dr. Britton -- We also have with us today Marc Turner, he has been key in execution of what Dr. Britton will be speaking toward today and he is going to join us for the end of the presentation and answer any questions you might have. Marc joined Gateway Foundation as the president of the Community Services Division. In this role he is responsible for the all community-based outpatient and residential programs across Illinois. Apart from managing the strategy and operations for community programs, Marc also oversees call center operation, sales and marketing and [indiscernible]. He comes with a strong background in over 25 years' experience in addiction treatment, -- running for-profit and not-for-profit addiction treatment centers throughout the country, specializing in high quality care with long term sustainable growth plans. Before joining Gateway, Marc worked with American Addiction Centers and managed multiple -- prior to being the CEO, he spent about-- Palmetto Behavioral Health System based out of Charleston, South Carolina. Let me make sure you have remote access, I believe you do, I will turn this off and turn it over to you.

>>DR. THOMAS BRITTON: Great, thank you so much, Jessie. As she said, I am Tom Britton, President and CEO of Gateway Foundation. Thank you very much to Marc for joining me. I will be talking through the next several slides but Marc is the primary author in helping make this a reality. Thank you, Marc, for your part in that. This is going to be a really meaty, very actionable conversation today. We're going to go deep.

One of the things that I like to do when I present is to really give different ways to see the information, to think about the information. There will be some stuff that I repeat in different ways but really present in different ways to flush at out. As I think about and in what is our goal in meeting with you today talking with Jessie, and what NAADAC has been thinking about providing the larger field of addiction treatment

and behavioral with insights into the behavioral strategy within our future. I'm going to walk through today really kind of first the state of the field, what is happening in behavioral health that is driving change that is driving innovation. I'm going to use Gateway Foundation as a case example because the time I've had here we've really gone from transformation. There is some good food for thought, learning lessons and hearing talk about how myself and my team at our organization have [inaudible -- off microphone] that. Then I'm going to pivot into virtual treatment and talk specifically through how we did the vision planning for what role virtual service has in our future, then, how we began to build a model of that. Then the last piece is how -- the product? I think that's the need for us to think through, what's the roadmap of change. Despite the fact I'm going to be talking primarily about virtual services, I think that when I talk about today is also going to be relevant relief for any inpatient you're talking about at all and efficient market doing. I encourage you to think very carefully about your own organization as it relates to what I talk about today.

I wanted to include this quote from Darwin which I thought was a great quote very much relates to where we are as leaders and as an industry. What he said was it's not the strongest of the species that survive, but the one who is most responsive to change. That's an interesting, we hear survival of the fittest, but really it's a much more complex thing. If we can't be prepared to fluidly respond to changes then our ability to be successful really goes down. If we look at the last 10 years with the field, we've been through rapid change for many years as an industry. But prior to the last 10 years, there was not as much change and consideration [indiscernible].

The first thing that I think has really pushed all of us to a state of innovation, and I think the same is true for when COVID began last year, I think the real driver started five, 10 years ago was the -- piece. If you look at the progression from the 80's until now really we saw from cocaine to crack cocaine to methamphetamine, heroin, now synthetic opioids and heroin. That progression really influences what does the face of treatment look like? Because opioids and synthetic opioids are really the primary drug abuse that is the most obvious -- we all know alcohol is always the biggest, 18 million people are in treatment for alcohol -- we are seeing many more people with opioid disorders. The introduction really made our patients much more medically complex, part of them are literally medical conditions that make them harder to treat. Or, the overdose risk and the withdrawal [indiscernible] requirements. That has really changed what does the person look like.

At the same time, we have seen an increase in psychiatric complexity of patients, the comorbidity of people presenting that have meaningful substance abuse disorders and meaningful mental health disorders have forced us very much to think about I can no longer treat one or the other. I really don't have a choice but to treat both.

Then we've also seen some social changes, the way that people connect today is different. I was thinking yesterday about myself, I'm 50 years old. When I was in college, we didn't have computers and cell phones really accessible to us. Here we are now and my kids have never lived without them. So that's change the way people connect. That makes another change in the way we need to treat people.

The final ones that really from a client standpoint have changed is that from a payer standpoint people with commercial insurance 10 years ago did not have consistent access to substance abuse treatment. Obama health care reform gave everybody the option of treatment. On a cost side the cost burden has shifted more to the patient than it used to be to the employer and to the payer, itself. That is going to force providers to be more selective in what they proceed. As you look at that green box down there patients are in a position where they are really easier, virtualized accessible treatment. But we also need to continue face-to-face and hybrid care.

As the patient was changing, our industry has been changing as well. From the payer form part, you've heard me talk about the introduction managed care and the increased accountability that comes from that. When I first got in the field, residence treatment was on average 42 days or --. Then it went to 28 days. Now the payers are trying to make it 10 to 15 days. That's a massive change for us as an industry. At the same time now we are focusing is looking more towards really alternative payment mechanisms and in doing alternative payment contracts that we know as providers are leaving the fee for service environment and moving to a risk sharing environment that is really outcome-based. That change, alone, is going to thread a lot of what I talk about today, because we need to be able to develop the right models of care, implement the right models of care, measure impact and communicate impact. That's a big, big difference.

The final piece I think is really meaningful here, from a consolidation standpoint, providers are joining the lot of providers [inaudible -- off microphone] the way we acquire clients has also changed. People are looking, historically, 15, 20 years ago, most people came in either because they knew somebody had gone to a place, they drive by it or they were sent by a doctor, therapist, something like that. Now, the large percentage of clients are really self-referred. The way we try to find those clients and our value proposition to clients is really meaningful changed.

Let me talk a little bit about virtual. Without question, I think the virtual treatment is the new frontier. It's going to be a pivotal and critical piece of the service delivery for the rest of the time that I think any of us work in this industry and I think it's going to continue to really escalate in its position power. COVID was something that I think, there were a lot of companies prior to COVID that had no virtual strategy at all. Gateway was one that already had a virtual strategy, we had some virtual platforms, but we never had the intention of accelerating the way that we did. But here today, I don't think there's many providers at all that have not integrated to point virtual care.

There are some questioners going around and some research that has been done do providers intend to continue virtual care after COVID is gone and the risk of face-to-face care is gone. The answer is yes. Virtual strategies will chip away at face-to-face strategies. If you look at the eventual capital investment coming into the industry and a lot of it is going to virtual care. At the same time, patients want virtual care. The expectations from consumers is really an expectation of a virtual with primary other medicines. I think the other strategic rationale is most states are approving payment for telemedicine. What that means, if that's not something you've been exposed to, if you come into for intensive outpatient programming face-to-face or if you participate virtually it's the same cost. So it answers an opportunity across [sounds like].

I think the risk to providers is that the integration risk, the building of the platform risk, brings a whole new set of competencies that many providers don't have or don't have the ability. Gateway is big enough that we can afford a dedicated IT team. We can have strategic teams, we can do lots of things to plan for this, build it, pay for it, respond to it. -- There's also the risk of data breach if you don't design it well and have

security features, people to client information. We obviously want to avoid that. Then there's the question that you may build it and nobody comes.

From an economic standpoint we are seeing, the revenue impact is a strategic imperative that we believe will [inaudible -- off microphone] but the capital costs upfront will be lower based on which strategy you go through and we will talk about different ones. But the operating costs can be all over the place. You need to think about as you build your own strategies, what's a low cost entry point? All you have is Zoom, and send people links to Zoom, that's a very, very low cost. If you want an integrated suite of services that [inaudible -- off microphone]. The other economic consideration is if we develop enrolled [indiscernible] services it is not a standalone thing, it integrates into everything else. We need to think about the costs of that.

We also need to think about what is the staff impact of that and how are they going to respond to it. Part of what it going to talk about a little bit is how we surveyed our staff and included our staff in thinking through those.

I wanted to talk a little bit about Gateway as an example of this. Because, the later parts then I talk about our unique -- response. I think you will understand them as they go through. Gateway is an example of one of the legacy providers. We started in 1968 as a small, outpatient program on the south side of Chicago. Shortly after, we opened a residential center. In the 70s we grew to residential and outpatient sites. Not massive, but at that time it was a pretty big footprint. We began providing in custody treatment in the 80s, treating people that were incarcerated for their crimes because of their substance use. For that period between the 1980s up until 2010 or so, we remained pretty similar. We began to diversify into commercial insurance which was really forward thinking kind of thing, my board at that time looked at it and saw if we didn't diversify our income stream and remain publicly dependent on funding then we would be in big trouble. If you are an organization that still relies solely on public funding either through grant dollars or fee-for-service build, think about the viability of that as -- to all of our strategic modeling that [indiscernible].

I came to the organization in 2015 and I was recruited because I been successful in doing turnarounds where I helped organizations that were struggling to really re-skin themselves, looking at all the stuff. The first year of employment we did a deep, deep dive in all the elements we're going to cover on this next slide, thought about who do we want to be in the future? What we knew we wanted to be in the future was a diversified, national program that served as many people as we could and that had an infrastructure that can support that. Today, we treat about 8000 people a day. We have almost 100 locations in 8 sites and we provide a vast array of services, everything from community-based outpatient treatment to facility-based, correctional treatment, to detox services, etc. I'm going to talk to that a little bit. But what we have to look at those earlier days, 2015 to 2017 or so, is for us to be the provider of the future, what do we need to change? This is the other part of food for thought for you. We knew we didn't have the right knowledge to be what we wanted to be in the future. We needed to learn more about how do you live in a fee for service managed payment service of public insurance. Illinois for example, all the payment had not been managed care and they shifted into managed care. Not just managed-care but like 20 managed care organizations, each of which had its own strategy. We have to figure out how do you operate functionally and that in the same with private insurance.

We also had to update our understanding of consumer needs and the payment needs and then think about the technology infrastructure that was needed to support all of that. When you make change like what we made you also have to update all the policy and procedures. In the time I've been here, we literally have replaced virtually every single technological component of our operations. We built, we invested about \$5 million into electronic health platform that could effectively communicate with payers with all systems with our clients and do a lot of data analysis for us. It was really a valuable feedback tool for us. We replaced all of our financial systems and we implemented something I was very excited about quality tracking that I will talk about that in a minute. But really from the top down, everything. We also needed to change the way we acquired clients in that we needed strategic planning. It's been a huge change.

As you think about your virtual service, as you go forward these are the questions you need to ask yourself, what do I not know that I need to know? What infrastructure do I need that I don't have now? Is there a different way I need to sell the product that we are not selling it now? Do I need to think

strategically differently than I am doing now? You can't make change like that without looking at your team asking yourself do we have the right people in the system to execute and be successful?

The first thing that I looked at obviously was my leadership team and to say to the people that are here today, do the people that are here today have this knowledge and competency? Marc is a great example of someone who spent his entire career in the for-profit sector and was very successful in operations. I needed somebody very smart in operations and I needed somebody who understood the for profit world. Because, if we were to remain profitable we really needed to re-identify how we were going to do business. We never left our mission, we still treat 50,000 people a year in Illinois who are publicly funded but we also treat commercially funded to people and also government correctional facilities. We also need to look at our medical [indiscernible] when I joined the organization they were doing very little -- there was a quality oversight of physicians, there was no standardization for physicians. So we recruited a very sophisticated medical director who's been such a rockstar, I'm so fortunate to have him.

Then you have to look a step below that. Do we have, do we have the right clinical staff, financial staff, utilization review staff, etc. We have really rebuilt our staff model so that we have new clients and different clients as a result of that.

What our program looks like today, primarily I am going to talk about [inaudible -- off microphone] because the virtual product we are launching will be mostly [inaudible -- off microphone] this is an easy way to talk about it. You can see all the locations we have and we have opened six, seven outpatient centers in the time I've been here because we saw there was a big outpatient need and we have grown that business quite dramatically. We also saw that for patients who have unique needs that were not getting met in a one-size-fits-all program, alcohol use disorders were one of those. These are specialty programs that we built and we rolled up to the organization, one of which I'm very excited about is our Out in Recovery which is an LGBTQ+ specifically focused unit what we found is people who are members in that community going into other parts of our organization didn't feel they were safe or hadn't had the answers of even as simple as where do I go to the restroom, what dorm do I sleep in? What are the issues that come up with my roommate, and made some real effective teachers from that.

I'm also proud that during COVID rather than just discharging everybody [indiscernible] because there was enough demand. We can't be successful in the virtual strategies fit into this if we don't know our acumen [sounds like] quality of care. As we evaluated that we wanted to look what are the past practice models we can design ourselves after. We partnered with the American Society of Addiction Medicine, for example, and had our program certified at the level to say we need that [indiscernible]. We partnered with Dartmouth University in the state of Illinois to say certified in our programs could effectively treat people with the [inaudible -- off microphone]. We have worked with our payers to become -- excellent and we knew we had a population of people that needed our level of care that in our current model were not able to do that. What we've also learned is that without a virtual suite of services, without technology, our ability to successfully execute this would not be successful.

I also wanted to know what is the impact of our care? The first thing that I did was we hired a consulting firm called Omni Consulting Institute in Colorado for a randomized trial with a group of our patients to track them for 12 months and find what happens after care? Where are they 30 days, 60, 90, 12 months out? What we saw was dramatic result for all the opioid drugs and -- stimulants that we have 90+ percent of the people had not used them at the 12 month point. 77% -- this number is actually in later numbers, I will share this with you in a minute -- 76% of people that had an alcohol use disorder had not used in that period but 50% had not used anything. What we learned is that even though we have these high [indiscernible] numbers for drugs they presented with, they were using something else. The benchmark in the industry is about 35% so 50% was good, but it meant half the people we treated were still using something or had used something over time. So we needed more information, but there was no way we could have a larger scale data evaluation system using technology. We built a couple things. One is now within our electronic health record without addiction monitor [sounds like] into it. That's a standardized tool that evaluates people's progress. Then, we built, I will go to this to talk through this little bit, then we've got an application that people to download on their phone, we connect that I have on my phone. It was a place where we could push information out, so we could send a brief addiction monitor to them, [indiscernible] and things like that. Then a social networking function within it the kind of like Facebook and a sense for Gateway alumni. We've got a lot of people who have downloaded that and used it. That's

been a tremendous tool. But there's not bidirectional communication, they can't get back to us, we can't communicate with them. There's no functionality for them related to their care.

If you think about population, I will talk to you about this in a little bit, the more information you get on what your patients are doing, the better you can influence the social indicators of success. Social determinants of health. So we knew that we needed bidirectional information. On the flipside this is what we have to do. In our virtual service, literally video-based counseling, we have served over 10,000 patients from last year when COVID began and we are averaging about 19,000 sessions a month. That's a really huge accomplishment. When I think about how many people are getting certain virtually right now that we've done research on outcomes for people who have face-to-face only, virtual only or a hybrid. What we found is that people who are getting virtual only slightly lower outcomes, but not dramatically lower outcomes. So we're pleased with that but we're also trying to figure out how do we make that --.

The vision before we began the project, and I'm going to walk you through in a few minutes, is that we knew we wanted, excuse me, patient engagement function to the virtual suite. That would be really allowing them some asynchronous triage and support, that would inclusively consider [indiscernible] and also have clinical information. That's where we are getting information back into our system. I will talk to you much more about that but what you will find as we built this what we envision versus what we have today is that we were pretty successful in making these things happen.

I'm slowing down in my page turning again. I think when somebody puts a chat up it...

We decided we needed to do a project on this. We tried to do it ourselves first. We reached out to some existing vendors that said they had technical, virtual service products. What we found when we vetted those independently is that none of them had the things that were on that previous slide. Some of them had some of it, some had other parts of it, no one had all of it. They came to a point we needed a partner that was smarter than us in this area, that had a competency in this area to really help us figure out what it has that we want, how we want to get there, and so forth. We found two consulting partners that joined

us in this process. One of the ones that's the most instrumental [indiscernible] strategies based here, in Chicago. David Smith and his team have been driving the addiction policy reform nationally and have been great partners in helping us think through this. If you're one who is going for CEU's I'm going to point out answers to some of these questions as we go along. I don't know, Jessie, if we are allowed to have people cheat little bit. But that box down there that says the most effective way to understand your organizational needs and challenges is to get representative stakeholder interviews.

That, we realized, as we did this was probably one of the most important places we needed to start for two reasons. One is for organizational change management, people needed buy-in. We needed to understand what was important to people and we need to get better understanding of what they found barriers to care were. You can see here from the project goals, the first part was to really understand current state of technology and what is our appetite for digital transformation? How much do people want to change? That alignment piece for stakeholders on the future vision. We wanted to understand, really develop the future state for new and existing clients. Then we wanted to prioritize because we knew we -- with every single piece. We wanted to think through what should be the first two and three things everyone should accomplish and on what schedule do we want to accomplish that? It's important question for you to be thinking about because the more you want to do and the faster you want to do it will dramatically influence your choices of what type of partner you are looking for. The faster you want to go and the more inclusive you want to go, the more expensive it will be and the bigger provider, the bigger vendor and the less personalization that you will have. That part of it was really identifying options, literally finding who are the vendors we want to put in this and understanding the total cost solution. And cost of ownership at least letting that into two pieces, what is the upfront cost to design the tool and what is the operational cost to continue running it.

On the back side of the project, where we are right now, it's been very successful in meeting those criteria, that we really have educated stakeholders that have been involved and I do town halls with our organization quarterly we have all employees join us. We've been keeping them in the loop on this as we've got along. You can see there that we surveyed 107 of our staff, interviewed nine specific leaders from our staff -- that represents about 5% of our workforce, 8% or 9% of our workforce. It's a good

representative sample. We also had some stakeholder workshops to have the opportunity to really kick this around.

At the end of this, we have been successful in building the strategy, identifying the vendors, understanding total cost of ownership and represent right now, this is the last two slides of the stuff as we are about to move into the RFI process to asking them vendors to give us proposals on participating in this. The people we included in the stakeholder interviews and workshops where we talked about them, this is one of the most important parts for us, the largest group you see here, 41% are counselors. These are people that often in organizational change are not consulted, but are the most important ones because they are the ones who are doing this day today.

You can also see we included our operational type people, those who do IT, strategy, finance, etc. The leadership. Ultimately a CEO's job is to set a vision for a job in support of the execution of that. But I can't be successful in that if I don't get total -- from everybody else. You can see the questions we asked here were really about how much do people want to? How ready did they feel we were? These prioritizations. What would excite them about it?

Here we use the phrase "organizational change management" a lot because we learned as an organization when we launch our electronic health record for example, we didn't do the best job. We didn't do a terrible job but we didn't do the best job in really preparing our staff to use it. That's different than virtual suites of service because it's such a huge piece of your job. But if you don't include people along the way and ask them those questions, I don't think you can be successful.

This represents the voice of our staff. You can see the first was that people were really excited at the option of increasing our visibility in the digital consumers' space. They want us to be out there like that. They also were excited about the fact that the thought that would open the door to more clients, that would really expand the number of people they were able to serve. Some of their concerns, some of their fears, using the electronic health record that I talked about, is they didn't want it to be chaotic. They didn't

want it to be challenging. They didn't want it to add additional burden. It was really important that we do it well that we evolve [inaudible -- off microphone].

The other piece, this is an interesting one because I'm in recovery and the 12-step community has been a big part of my own recovery, our field has leaned on the premise that social interaction with face-to-face connection is one of the big contributors to recovery. I believe that is true 100%. There workforce is worried about that. I think as you develop virtual solutions, you have to think about how do you maintain that outcome? How do you create connection with people? How do you maintain them?

Then, finally, we asked staff what does success look like, it was really about client satisfaction and engagement and the ability to deliver the things we wanted to deliver.

So digging into that a little bit deeper, this is the reflections on readiness. I like this one a lot because it was really their feelings of where we are. What you can see there on the top is they felt we were, they strongly agreed that they are very important to us, that doing this was a business imperative, that was 100% across the board. They also were willing to invest time and energy, which is another big one. People can say it's important, but if they don't say they're willing to put energy into it, it's not going to help you too much. They agreed strongly if we didn't do this in a way that was easy for the patient it would fail.

It got a little bit weaker -- their belief system about our ability to do it and our readiness to do it. You can kind of see that going all the way down. They also didn't feel we had a vision, which is really fair, because this process was really designed to build the vision. You move a little bit further down and they brought up some stuff [indiscernible] for us which is do we have well-defined governance to really do this? As you think about governance, you have to think about patient confidentiality, you have to think about PHI, you need to think about risk management and data breaches and things like that.

Finally, they didn't think we had the KPIs, key performance indicators, written out. That is such a great [indiscernible]. You will hear a little bit more of what we ended up defining those as. They also didn't think

we were totally prepared to work from department to department. I think for some of the ones that answered literally could be from nursing to clinical to operations, etc. They wanted to make sure that worked well.

Getting into some of the business challenges, as I talked to these I want you to think about are these the challenges you see, as well? Are you having a harder time with patient acquisition and things like that? If that's not a big one for you that may not be [inaudible -- off microphone]. That box in yellow is another one you might see on the quiz. No matter what, you need the mindset there's not going to be any solution that is a one-size-fits-all. You really have to pick your best and most important things. As they prioritized it, they thought the biggest business challenge we have look into the future is that we needed to continue to acquire new and more patients and that we wanted to make it easy for patients to join us, that we wanted to grow the share of commercial patients. Those are the top three most important business challenges that they thought were facing us today.

In our markets, there have been dramatic entrants, new residential programs competing for patients, new outpatient programs competing for the same patients. There's the massive -- proliferation on Medicare [indiscernible] so a legacy provider like us that has a big ship, it's hard to turn. Going to have a little bit further that they really thought of as a more important to offer more outpatient status. They wanted to reduce cancellations and no-shows, which is such a challenge. They also wanted to increase our residential programs. Then we asked them what are the most important functions that should be here? You can see in that number one part of that is, both of these are really patient engagement. But what is the front door, they wanted to make sure it was part of the front door and they wanted to make sure it was part of the long-term, both the assessments and the virtual visits. As we get out a little bit, I'm a patient at Northwestern medical and requested has a fantastic app that when I go in I can look at test results, I can schedule appointments, I can send communications to my doctor, I can do all these pretty amazing things. In addition treatment, it's not as individualized that on the schedule would be the most important thing. But it's very important. It's also important to this group to have online community supports where people can be connected. -- Key themes, I'm going to talk a little more in-depth about each of these boxes, but from a business imperative really it was all about -- that we as a business and each of you as

businesses need to remain viable and not get outdated that was certainly part of our biggest barriers were really around execution.

The measurements of success were really about ease and utilization of the project. Getting deeper into this, digging into this a little bit more on going into the business imperative, the first one that you heard about was the growing share of commercial clients, but also about staff capacity, we are having a workforce crisis in behavioral health but that is unlike anything I've ever seen. It was really [indiscernible] as you think about virtual solutions of how do you use it in a way that takes work off of your nurses, counselors and your teams so that they can be more productive and do more of the things that matter and that there also relates that you can't make a virtual product it's hard to use or else it's going to take more time for them. It was also important we were able to communicate with referral sources that this is something that was a challenge at a lot of places and that the [indiscernible] product is competitive but the digital capabilities are not.

One of the things was another piece as if I went back to that state of Illinois slide, if you don't know Illinois, it's kind of a tale of many worlds, we have Chicago which is the third largest city in the country, but we have very rural cases that have very different political values, different levels of income, different access issues. Virtual is a tremendous opportunity to treat spaces where you couldn't afford to have a standalone program but you could connect with them virtually. The biggest perceived ones, one of them is really that this is a complex population, it is a -- populations are they able to use virtual services? Resourcing from a staff and financial perspective, that is something that we need to figure out solutions, making it easy. We need to figure out how to do the positional change so that it is adopted both by our staff and by our providers.

As I go down a little bit deeper into this, into what the staff said is that they really wanted from digital capabilities, and you will see this as a talk about this in a minute. One of them is that it is a single sign on. They don't want an app where have to sign in to 10 different things. Something we've done with our internal technology is we used to have to go out and log into our system, then log into our financial

system, then log into our performance management system. We do have a single sign-on from employees [indiscernible] it was an absolute, critical required function that bidirectional communication.

As we go into those different kinds of things we also want to make sure that you can do individual sessions and group sessions. That's something to be thinking about this for a professional practice that all they do is [indiscernible] services you don't need the same technology as if you have a robust variety. But we also wanted to have content in there, people can watch videos, read educational materials, that it would engage them in that way. We wanted to have a way they could pay for their services. -- this product is not just about adding revenue, but it's about adding outcome. So the more people we can serve the more people we can treat and being able to measure and drive those outcomes, that is a fantastic and absolutely required [inaudible -- off microphone]. If I go back to the alternative payment models, the payers, or even the centers of excellence that they have clear algorithms that say you need to talk to patients, for example, this many times. You need to talk to them after they leave treatment in this frequency or else you don't get those kinds of things. That's kind of where we were without. In a minute I'm going to get into a little more around product itself.

Getting back to the prioritization, this is a different way to look at it into these three different buckets. One of those -- and this is again for you to think about -- is are you going to use this for new patients? If so, that will shape the way it looks. Are you going to use it for virtual care? That shapes how it looks. How much ability do you have to lift? If you don't have a lot of ability to lift when you don't have a lot of resources, that changes your abilities. Part of why I'm so proud of why it's so important to us to do that stakeholder assessment is we want that to do that. Another one you might see on your quiz is that organizational change to client adopted adoption [sounds like] can be one of the biggest challenges to you. Let the entity what we felt we wanted to be able to [inaudible -- off microphone] one is that care management, which is not something that Gateway as an example, that we provide the acute treatment up front, we do connection treatment after they leave. But then the nine months or so after their acute phase of treatment we are not really offering improved care management and there is not a -- for [indiscernible] service models. Clinical outcomes you will see that is 1A and 1B that those are [indiscernible] we needed to improve outcomes for our patients.

We also wanted to build a better relationship with our patients. One of the things we can do with virtual is that they stay in a relationship with you. You've heard me talk about increasing revenue. Part of our goal is to extend our footprint. In Illinois you saw where we were you can also see where we weren't. Then bring operational efficiency.

Our last case and this is one for you to think about is we want to build this and not just use it ourselves but also have it be something that we can license to the providers, for you on the phone who don't have the ability, we want to be able to share the tool and that if it from the tool. Let me talk a little bit about what the service model looks like, where virtual treatment fits into that. Then I want to talk about building the product, itself. Gateway in our wheel of services is [indiscernible] on the wheel of the right that we provide psychiatric residential care, intensive care, etc. We provide withdrawal management, MAT and aftercare. That is the phases of acute care. If somebody walks in the door on that spread on the bottom our first point of contact is really assessing them and triaging them to the right level of care. Then there is the acute period, which the intervention, they're going to experience that they're going to experience virtual support and peer support as part of their treatment. Then they're one where you see maintenance, this is really our future state goal of working with insurance companies to get them to fund this and to buy-in an episode of care. Then the fee for service model is not optimized, it does not work well for the patient, it does not work well for the providers. We need to reach a model that says if we really want people to get better, they need 12 months of engagement. If you look back up to the graph we wanted to make sure there was no wrong door. We wanted to make sure if there was, if anyone wanted to come in for care at any point we would make it easier for them. With [indiscernible] tool that is dramatically undiminished. As you look at the digital map, you can see the front door part of it is really that they could connect to it from work, they could connect to it from a mobile device, from home, from their office, the doctor say hey, let me walk you down the hallway, get you a video triage appointment with Gateway. Really walk them through the part [sounds like]. As they walked through they can understand scheduling, wait times, pricing, etc., that they could receive the clinical encounter pretty well and really move all the way through to the end of that model.

As we think about the virtual outpatient is a new service line, this, the industry, there's a massive accelerated rush to the market right now. Of new companies that are trying to offer standalone virtual services, meaning they have no brick-and-mortar anymore, I believe strongly, and this is something I communicate to legislators and payers is that I don't know you can provide best care with virtual only. I think it has to be a partnership either with a separate company that is virtual or separate company that does face-to-face or one that is both. We obviously want to do both. So for us this is going to be a new business line for us that will include on-demand virtual assessments. This might be using the EAP [sounds like] as an example, if I were let's say I get in trouble and they say you need to go to treatment and in the office nobody can connect [sounds like] we want to have as part of our product inpatient and outpatient session. We also want to do community education sessions, engaging families and communities and trying to give them opportunities to check this is really kind of a graphic that represents what might this look like on some of these.

You will see the language "app of apps." I've learned a lot in this process about stuff I really didn't know a thing about like the slides I'm about to walk you through unfortunately I had to learn [indiscernible] one of the things about app of apps, I think of it kind of like a landing page where everything is piled up. Landing page has all kinds of links, for example. This is what we believe ours will look like. And the ingredients we think will be included on there will be links that connect them directly to virtual service. There will be links that are bidirectional communication. They will be links for case management, there will be links for contingency management, for medication assisted treatment, those administrative pieces. I will walk through this in more detail, but in essence that's what is going to look like with actions themselves.

All of that is high-level. Now you've got to figure out okay if you have an idea of what you want, you got to figure out how do you build the tool? So, there's kind of three ways you can do this. This goes back, as I talked about this, literally, picture that picture of the phone with different buttons, the first is that you literally built from scratch app of apps, what it sits on, then all the different functions that you provide. This is a tremendously complex process that you need a very [indiscernible] team or you need to pay contractors who know how to do this to build video solutions, to build contingency solutions. This is not when we are [indiscernible] as a Gateway, it's too complex, too [inaudible -- off microphone]. The second is partnering with a vendor that has the app of apps, they might have some of the capabilities, they don't

have all the capabilities. But they have the ability to integrate other worlds outside of it. That last one is somebody that has the wrapper only. They don't have any services there but they are [inaudible -- off microphone] for you to lower, to sink stuff into it. We are most likely as an organization [inaudible -- off microphone] number two, somebody who has some of it but not all of that that can affect that and integrate that.

What that looks like from a customer experience is there are three ways it looks to the client. What is that it's completely embedded. What that means is for me, if I'm using my phone and I push, that all of the information that happens in there, it all stays in the system, itself. It doesn't go out to us and for example, it doesn't go out to a contingency management company. That really is [indiscernible] in, that's [indiscernible] because there's a lot of companies doing that and doing things we want to be connected to that would be willing to white label their stuff. By white label, I mean let us call -- we connect. They want the brand.

The second phase is really the ported, redirected. This is not an attractive option to me, either. What this would look to me like as I would see buttons that say things like Zoom, contingency management, etc. When I push them it sends it out to Zoom and I need to log in to visit him. I'm no longer in the system. With that, one of the biggest challenges is number one, you don't have a brand but also the education data going back and forth is weakened in the solution.

The solution we are most likely going to go to is an integrated one. Thus, if you think back to option 2 I talked about earlier, where you're starting with an app of apps that has some functionality, thinking about what are the most important personalities to you as you're starting [indiscernible] does them but they have the ability to also add links to other, but it's integrated. It doesn't make you go out a Zoom for example. It connects you to Zoom but you don't need to log in. In this type of structure you have a lot of ability to get information, to give information and to really be allowed to do it. There's challenges to it. But we believe this is most likely the best solution.

As you build the blueprint itself -- this is going to get meaty, forgive me if you don't want meaty -- one of the places to start as you think about the design of this is what is your electronic health record capability as we thought about my avatar which is ours we built this thinking about this coming down [inaudible -- off microphone]. It is able to integrate with virtually anything we want integrate. On the right side of this graphic you see patient facing. These are all the things the patient will see. We'll talk about those in a minute. The right thing is everything that benefits the team. They need to connect in my mind to really relate the connection [sounds like]. Below that this is one of the acronyms I had not known before, I knew the acronym but multiproduct, CRM stands for customer relationship management, Salesforce is an example of this. This is a data warehouse that is able to help you understand your client behavior. This is the sales point. One of the softwares that we have in our call center for example is, if I've ever called before and I call from the telephone number, the software in this system that says this is Tom, it automatically opens my record, it shows all the conversations we've ever had before, -- also shows, we want to have those active. Getting into the patient side of this, and I will walk through the patient side of this, but in essence these pieces will be decided most important to us. We wanted to be able to change behavior. Wanted communication. We wanted peer support therapy, etc. That's why these ended up for us on [indiscernible] solution.

As I talk about this, this is what I want you to think about, which of these pieces matter to you. The administrative services, scheduling for example, that's where we literally go in and make an appointment. That's important but not the most important, that we will probably get to that in a couple years. The other is that they can access their data. That is important to us. We wanted to be able to see things to stay current and active in what's going on. The billing, this was less important to us but obviously, it's a good function, we want to be able to push out bills which is a big one for your financial staff to give them the flexibility the putting in a credit card or something like that. That's with the administrative pieces look like.

A behavior [inaudible -- off microphone] standpoint, from a research standpoint, we know that rewards and incentives work for patients, it helps them to better, the outcomes are better. We also know that prompting them [inaudible -- off microphone] and outcome. It helps them. These are things where you can send a message saying have you gone to a meeting today or did you go to your outpatient session? Did you remember to take your medicine? Did you call somebody today? These are really prompting

whatever it is on the plan send up to get them to try to do the behaviors that create better outcomes. There's a lot of personalization you can do to this which I like a lot.

Next one is really about the asynchronous community. One of the things that's very important to us is that has recovery content in it. There's some companies that do this really well that have engaged with interactive video that have stuff people can [inaudible -- off microphone]. We envision that our application to families, it isn't just going to go to clients. Families often want to read about it and know how they can help their family. That chat bot is really cool, this is something they can chat with someone, I'm sure you've seen this online that as you start to chat there are some things they can do online. This confuses some of our [indiscernible]. Define what is the resource finder. This is not as important to us but it is a cool feature. This would be for example if I go up to Milwaukee, where can I find my AA? Or is [indiscernible] that has a GPS locator that says here's where there is a -- meeting, whatever it is. It's able to tell you that, that would be a cool feature we hope to put in there but not necessarily one we try to prioritize right off the bat.

Then there's really that community, if you think back to what I said in the beginning about community connections, that this is the network relationship, it is critical to us that our patients are able to have social network. Social network and peer recovery support is one of our must-haves. That community referral type stuff which is similar to what I talked about before but not as important. But is important nonetheless.

Finally, this is what each of us need without any questions, synchronous therapy, that's the one where you are literally doing counseling. Our product, the -- of any project product you would like to build, that is a must-have, there is no question [indiscernible]. Having cognitive therapy in there that is a good thing, having [indiscernible] is a good thing. But these are the therapeutic things that the system will have that I think are important for you to think about.

This is the side that is for your team. It will benefit staff and benefit outcomes. The first one this is something that, my doctorate is in Public Health, we will talk a lot about population health, this is a

different form of population health that was the work for me to think about. This is where everything that the app does, everything the patient is on the outcome ports over to information that your staff can see and it creates opportunities to use artificial intelligence that will influence our ability to create better outcomes. An example could be if there's a question there that you [indiscernible] let's say there's one you do every day, four question that says that I sleep today? Did I eat today? Did I call my friends? Let's say those are the four questions. If I answer those questions in a way that suggests I'm in trouble, it can tell the staff that they can reach out to that person. If they answer in a way that is good for the patient it will report them into things like that. So this is a really interesting and new way that truly transforms care. I think one of the challenges of outpatient face-to-face care for example, is we don't really know what's happening when we're outside. We have to wait until they come back. We have to give them the opportunity to tell us that we're flying a little bit in the dark this is a really strong value add that I think each of you will benefit from.

One of the things for you to think about as well, that was I thinking about the application in our corrections business, too, does the product that you choose have the ability to interact with the wearable devices? These are the ones come there's the one that is for example a breathalyzer that I can use and it goes into the app or one of the devices I could put on my leg shows if I've been drinking. Those devices are pretty cool. It also would be the GPS functionality. This feels a little big [indiscernible] to me but that can literally beep you if I go into a place that's a bad place to be. Where I am, if I went to where drugs are sold it's going to tell somebody. On the technology side -- I've got to tell you, ADT stands for abstract data technologies and that acronym doesn't make much sense to me -- but this goes back to [inaudible -- off microphone] it interacts specifically. What information doesn't pull, how does it notify staff and how does it work? This is an important back room function, in a sense of --.

The last piece going to share that are going to turn it back to Jessie and ask Marc to join us on audio so he can answer some questions, you've got a better sense now of some of the things to think through. You've got the slides you're going to be able to look at these later. I'm open to talking to people if you want to reach out to me. But none of this is worthwhile without, if you don't actualize it. For us now that we understand what we want, now that we understand what the different solutions can look like, what the ingredients can be, then we're at the place where we can develop some requests for information to what

do you do. What does your product have and what does your product not have to kind of compare back to [indiscernible] and say can it do population health stuff? Can it do virtual therapies, etc.? If you remember the solution we're looking for is one that has some things in it already and has the ability to point other stuff. Based on the RFI responses, we can then do a request for proposal. In building the request for proposal, you need to look at the solutions that you now have an understanding of functionality that they have is do we then build a product from this that is possible? Because I may find out there is no solution that can do the top three things I want and if I can't, what are my next choices?

The final piece is once we do this request for proposals is if we identify the five, let's say we identified three vendors and they're strong contenders, we believe they can do what they can do is we are then going to put on a request for proposal for them the starting contract negotiation standpoint. Then move towards for hiring. This is not a quick process. This is a time intensive process, but a very exciting process. I give you a lot of information. I noticed there were 18 we started and 18 will be finished so I'm pleased no one hung up on me while we were talking. With that, Jessie I will turn it back to you and ask Marc to turn on his camera.

>>JESSIE O'BRIEN: Thank you so much. We do have some questions here, I hope you guys can answer. If participants haven't had a chance to, go ahead and read through the questions. I like the thumbs up. Like any that you see. The first question asked, "Are there any rule out criteria that make a person inappropriate for app use, tech services."

>>MARC TURNER: The answer is yes and it really is based on assessment. The same is true when we think about levels of care. There are clients who are not appropriate for an outpatient level of care and need residential or higher levels of care. There are clients who may, we often find clients we say would benefit from a higher level of care residential, but we're willing to try them in a lower level of care in terms of that dialogue. So use some of the same skillsets that you use now when talking with people. Part of the criteria, I think there was another question in there related to when is a client appropriate or not, for us, some of the experience has been, there have been times were in a particular geography, because of COVID, we're not offering a face-to-face outpatient service, so it's a matter of how do we help them? We

probably stretched that in places a little more then, we went. The other is that as we envision, as Thomas said, this being open to people who live in rural areas of Illinois or other parts of the Midwest, it's really important to think about, is the client going to participate in virtual services or receive nothing? Certainly, if the virtual is available, we want to offer that because we want outreach. But, to answer that question, obviously, if somebody is actively using or actively in withdrawal and cannot participate in programming because of their use of substances, that they're not appropriate for engagement in a virtual or app-based service.

>>DR. THOMAS BRITTON: I will add one thing to that, too, Jessie. I think the other is also patient choice. Some patients are just not going to want to do it. Other patients will get in it and will realize they're not doing well. That's part of our job to see, is really monitoring, are they benefiting or are they not and pivoting. The last piece I would share this if you think of the triage and assessment piece, we're going to see patients who have safety issues that are more comfortable that we would [indiscernible] seeing them eye to eye. We are anyplace we can't provide the service physically I think that would be a patient that we could say we would love to serve you but I think you would be better with this local resource.

>>JESSIE O'BRIEN: Would this be something, to follow up when he talked about outpatients and it sounds like it's very closely tied to outpatient but would it be progressive? Would you give them access if someone is in residential there's features of the app that they would like would you make some features accessible to somebody in that level of care and then, as they progress through treatment, make more accessible?

>>MARC TURNER: Yes. Tom talked about there being resource based information within the app, things that people could read, videos, I think it's important for all of the participants in the webinar to understand we have an existing app we are using, we have an existing delivery of virtual services through Zoom. So we have a fundamental product, a lot of what Tom has talked about is our desire in terms of moving into the digital future to be building a better platform and enhanced services. So in answering a question like that I can say to you that we can, a counselor in residential can sit with a client and help them log in and

see some features and can actually do therapeutic assignments in the app now that they can be participating in while in residential treatment.

>>JESSIE O'BRIEN: Okay. I am going to stick with the clinical once then there's a sort of administrative one I will get to. The next one is, "How do you create boundaries for staff when they are on versus off, for example if a client answers before you spoke about the check in question, the assessment, with concerning results in that person's counsel is off duty. Is there a contingency plan? Does that increase the company's liability that the information is out there and the company is obligated to respond in some way?"

>>MARC TURNER: Yes and yes. When we think about asking a survey question, or a check in question, their predominant application for that is now, let's get that survey data so that we can have it before group starts so we can review it. So we can know who we need to be attending to or adjusting the group topic or the individual session topic in terms of that. We are not at this point sending out 70 -- week check-in kind of questions at this point. As we move forward with being able to do that, we will be able to have a person who is on that we have a call center that operates 24/7, that has certified drug and alcohol counselors that work within it. Of the things that would be coming in, we would have staff on duty that would be able to respond to that as we expand what we sent out, you do have to have the staff to stand behind it.

>>JESSIE O'BRIEN: Almost like a crisis center in a sense.

>>MARC TURNER: Yes.

>>JESSIE O'BRIEN: Got it. Given the various level of comfort with technology in staff will it be required for staff to use the app and how do you get them comfortable?

>>MARC TURNER: We have the benefit in that everybody uses in America electronic health record so everybody has a certain amount of technical knowledge in their ability to do that. Tom talked about in his presentation about change management and really talked about in fact a lot of the lessons we learned when we converted from one electronic health record to the current one that we have almost 3 years ago in terms of how do we help staff with their comfort level. So there is certainly [indiscernible] staff using the app in a way that is different from the way they use the electronic health record, it's really important that their voice be heard, that's one of the things Tom spoke to in the slides, as well as we are very good at giving them the mechanical training of it. Right now, we've got a limited group of staff that are working with their app and they're all folks that have a great deal of technological ability, much more beyond Tom and mine, although both Tom and I have the app on our phone and we have the ability to use and engage in it at this point as if we were customers of Gateway in terms of that.

>>DR. THOMAS BRITTON: I will add something to that too, Jessie, when we in March made the decision that outpatient services were not safe to do face-to-face, we overnight, pretty much virtualized huge amount of clients. The way we managed it at that time is an essence if we have 10 outpatient sites, that 10 outpatient counselors that were seeing people at those sites would be seeing the same patients but seeing them virtually. So it was almost literally like you student [indiscernible] step back and are virtual. Not all counselors like that and not all were good at it. Marc and I, in meeting with our team, they're looking at the outcomes, have really come to understand that we need to prepare staff very differently. The way you engage clients in a room, and I remember my first group of counselor training they talked about you watch body language on all those different kinds of things, you don't get information the same way. We are training differently. There is also self-selection. My vision for the long-term future is that we really have a virtual -- to where anyone who received virtual services is treated from that team that anyone who is face-to-face gets treated from those teams. We are working with the same with our prescribers that we will have a virtual team of prescribers and a physical team of prescribers. Those will be people who self-selected and really got virtual advanced training on the [inaudible -- off microphone].

>>MARC TURNER: One of the decisions that we made was that group sizes could not be unlimited, which they never are. If you have in person you can do a reasonably good job if there is a didactic presentation, to a group of 21, 22, 23 clients. But we decided on a Zoom platform that we really got to

keep the group down 15, 16 range so that the windows are big enough that you don't get too, because any of you who have been on the Zoom, you can get 25 on a screen, those windows start to get pretty small you don't really get as great a connection as you do otherwise in terms of that. That's one of the features, we've learned a lot since March 2020 about what is best practice or what isn't. As Tom said, some people are better at screen sharing and at being able to use the chat features and being able to do some of the things that work really well in a virtual platform. Others have struggled to develop that skill set. But we bring people along and help them get better at it.

>>JESSIE O'BRIEN: That's great, I think we're all -- best practices and not so good practices, as well, right? This next one, for many small organizations, starting the dialogue about adding an app or tech system requires a level of knowledge that many in the organization don't have more than simple words, integrations, KPIs, compatible platforms, to embark on creating something like this can be overwhelming. Did you use a consultant to help develop this sufficiently, securely and safety?

>>DR. THOMAS BRITTON: I will take that one, Marc. This, without question, I touched a little bit on this before, as you do your own analysis, if your agency is small it meant literally your leadership team in a room talking about it. It may not have to be, I don't think a lot of small providers will have the resources or the competencies internally to be able to do something like what I talked about today. I think that's the kind of questions you talk about is if you know you don't have those resources. Some of these cost literally \$1 million a year. I've worked with agencies, I think my first agency, like a \$3 million top line. That's pretty average, I think that is looking for the partner who can do it [inaudible -- off microphone]. A part of why Gateway, frankly, was to develop the right tool to be able to license it to providers, we see that as a contribution of the field, there are theoretically 76,000 providers in the country, 96% of them have less than [inaudible -- off microphone]. That's not enough revenue to do the kind of stuff necessary. You most likely don't have a sophisticated electronic health record for example. Health record is not sophisticated it can't join with something like this.

>>JESSIE O'BRIEN: Got it. Some quick questions, can the reminders to check ins be automatically sent to clients through this app?

>>MARC TURNER: Yes.

>>DR. THOMAS BRITTON: Yes.

>>JESSIE O'BRIEN: I figured. And this the answer, it's going to integrate with your EMR and EHR?

>>MARC TURNER: In fact it does, one of the things we've already done with our app, we've got the [indiscernible] built in as our benchmarking tool that we administer at admission and treatment and plan update and at discharge. We can send that up through the app 30 days after discharge, 90 days after discharge, and that data comes back to integrate into our EHR. We felt that with a special API in order to be able to measure outcomes as Tom was talking about outcomes. We will be able to do that with other features that we can. We can also push things up [indiscernible] integrate back to the EHR so we have sent out a survey to alumni when we were considering taking some of our virtual services back to face-to-face and thinking what is your appetite for that, are you happy in staying in virtual to brick-and-mortar during this current situation? And we could get a survey back to them in the aggregate help us strategically drive when it was time to open the doors between real rooms and chairs in one of our centers.

>>JESSIE O'BRIEN: Also, I don't know the exact name of the acronym but API is essentially a technical branch, it speaks to two different apps that allows data to flow?

>>MARC TURNER: It's the handshake of information that allows the flow of the conduits, the plug-in.

>>JESSIE O'BRIEN: Great. I have so I just wanted to make sure our listeners know that. Please say more about the national digital engagement platform. I googled it but didn't find it.

>>DR. THOMAS BRITTON: I read that question and please can whoever asked that question can put a little more clarity there so we will come back to that one.

>>JESSIE O'BRIEN: How well can we distribute the RFI's to reach the developers? Is there a list of potential vendors?

>>THOMAS BRITTON: Part of, we started with a big list of providers and have trimmed it down to a smaller list of providers. One of the things our consultants are doing for us some preliminary screening to determine -- that will --, really, a pretty clear form, it's not a huge qualitative written thing of a checklist. We either do this or we don't do this.

>>JESSIE O'BRIEN: Got it. Are cell phones with apps loaded provided to clients for those without the technology?

>>MARC TURNER: Not currently. It's a great question, though. Something that is happening in certain places is there is communities, governments that are buying phones for example. There are payers that are making investments. That is a value proposition that we are trying to push with our vendor partners. But we will have defined it to do on our own.

>>JESSIE O'BRIEN: I think in New York the agency I was formerly employed did that, the resources to get people linked very good -- question for sure. What is the commercial insurance reimbursement structure for Zoom? Do they prepay?

>>DR. THOMAS BRITTON: That's interesting. One of the costs that we bear as the provider is that we are the host. Any application resources we provide the patient is something that we pay for. If you think

about a point of reimbursement, I will just use intensive outpatient intensive how we use that reimbursement is to pay for the services [indiscernible]. As you think about the 12 month episode care that I talked about is that people may have heard the acronym of PPMM price per member per month is not there are payers now per states that say we will give you an extra \$45 a month for example for patients.

>>JESSIE O'BRIEN: It's interesting you just said something I wanted to follow up on, the price per member per month. I don't know if this is what you are referring to, for these apps, I'm actually looking into LMS currently in [indiscernible] by learner. Is the app price for person you serve, if so how do you offset, do you eat that cost or does it raise your rates and will insurance pay for that? How does that work?

>>THOMAS BRITTON: It gets into the questions that as you think about what solutions you want that one of them was building but you need to put a lot of resources into [inaudible -- off microphone]. If I think about one of the products we have in our current Gateway Connect it is called Care Form [sounds like] this is a social network environment for patients that we pay a fee for each patient who participates in that. That's part of standpoint that we don't pass on to the client, that is part of what is helping drive outcomes. That is part of the find when we got some quotes there were some quotes we got back, the total cost of care that were so much bigger that it really made those not possible solutions. We got one that was literally -- to operate. There's no way to generate that much revenue from this type of. That is part of the calculus we need to think through.

>>JESSIE O'BRIEN: So we got the response back about the digital platform. It was right after the Omni project context slide that when you mentioned app of apps I could have sworn he said budgeting national engagement platform. Maybe I misheard.

>>DR. THOMAS BRITTON: I think that that maybe when we have this circle back on, I don't want to misquote that. Can you say which slide you think it was, Jessie or Marc if you know?

>>JESSIE O'BRIEN: Right after or on the project context slide when you mentioned app –

>>MARC TURNER: Tom, if I were to guess, I think what you are saying is we are trying to build a platform of as a rapper called app of app which would then be nationally as a platform. I think when you were talking about the aspirations that we have out of this project in terms of what will be a product as we finish and build out from where we are going. I think that was the context of your comments that perhaps they were [indiscernible] on a key piece of that. That would be my guess thank you think you're exactly right. I think if Marc is correct, which I think he is, is that we are expanding into other Midwest, that we want this to be something that we can roll out. There is not to say, there's a lot of products [indiscernible] that there is not a product like what we are building on the market today.

>>JESSIE O'BRIEN: That's perfect timing because it's time to wrap up. But surely this was so informative, I loved the discussion, there are so many questions answered and you guys provided valuable case study in ways to think about for organizations how they might want to incorporate this into their own structure whether they create it themselves or maybe someone will develop one they can then --

[FINAL TEXT CUT OFF BY SOFTWARE MALFUNCTION]

[END TRANSCRIPT]