Collaboration or Competition Who Owns the Healthcare Dollar

Diane:

Good morning everybody, my name is Diane Burfeindt. I am Vice President of Presbyterian Senior Living. We are a senior living provider, mostly in Pennsylvania. We have 13 continuing care retirement communities and about 26 affordable housing. And I will be co-moderating this panel today with Bill and what we are hoping to accomplish, we were just talking if you were in this morning's general session, this should be a great addition to what was just talked about. In terms of really defining value, I think David Nash said it when he said defining value is hard and it depends on your perspective. So that's exactly what we hope to accomplish today with this session and really give you a bit more in depth into as the title says, Collaboration or Competition, and really give you a little bit more of an insight to that. With that, I will have Bill introduce himself.

Bill:

Thank you, Diane. Everyone, I'm Bill Shatraw. I'm our Client Success Executive at Remedy Partners, now known as Signify Health, been with them about three and a half years and we're really a convener for the Buke CIA program and moving into other aspects of value based care. So we help hospitals, health systems, navigate that episode of care, that care continuum if you will, down the line. So thank you, Diane. And we'll go right down the line here in terms of intros.

Matthew:

You bet. My name is Matthew Harbison, I'm a practicing hospitalist by trade and have recently moved into a system leadership role at Memorial Hermon. I oversee our care coordination, which includes everything from home health, post acute, and then I also oversee our hospital medicine program, which we have recently in housed and supportive medicine so really trying to get coordination across those elements of our organization.

Scott:

Hello everyone. I'm Scott Ford. I'm the National Director for Post Acute Network Development for Ascension Living and Ascension Post Acute Services. I've recently moved into my role and I'm in charge of supporting a cross functional team across all of Ascension that's aimed at developing our 5 year post acute strategy. Prior to that, came up through our accountable care organization within our Austin market and came to Ascension with a background in home health and hospice as an operator.

Jim:

Good morning, Jim Lydiard with CareMore Anthem. I've been with the program for about 10 years supporting our senior living segments, which include our ISNIP programs and our at risk care delivery mobile solutions. Overall, we're currently supporting about 12 different states and have about 1,000 of our long term care communities that we partner with and develop strategic networking solutions with.

Skelly:

Hello everybody. I'm Skelly Wingard. I am a regional director for Kaiser Permanente in Northern California. We have 21 hospitals and about 12.5 million members and I'm responsible for the care coordination and care delivery across the continuum and within the hospital. Prior to that, I have actually worked for Kaiser for about 4 years and prior to that, I worked for a company called Ensign and we were self conveners in the bundle payment for care improvement initiative.

Diane:

Great, thank you. So as you can see just from the people that we have up on the stage here today, we really are trying to get those varying perspectives.

Diane:

So the way we're going to do this, we have a couple of questions that we're going to start out with. We're going to run through as well a scenario to start to get into the detail on this. We are going to leave about 10 minutes at the end for questions and answers so if you could hold any questions that you might have until the end and hopefully, what we're hoping to have is an engaged conversation to hear today around this issue.

Diane:

So, I'm going to start off, Skelly, I'm going to start with you and ask each panelist this same question, which is why does your organization care about risk sharing and value based care? Pretty basic but I think it really gets to the heart of your perspective on this.

Skelly:

Yeah, so, well at Kaiser Permanente, we bear full risk, right? We are a pre-payment model. So we actually are one KP with the health plan. So the payer, the hospital, and the med group, we all have separate tax IDs but ultimately, we understand that we really cannot be successful in healthcare without each other. That also expands into the post acute space. We know our strengths and our weaknesses. So ultimately, we don't excel, shall we say, in the post acute space as it pertains to skilled nursing, as it pertains to all of the outside aging population living spaces. That's not the business that we're in so we have to take risks with our partners. Ultimately, in order for us to be successful, we have to partner very very closely and we do that and we monitor kind of the quality with our partners. And so ultimately, the closer that we partner, the better the quality the outcomes are for the patients.

Diane:

Thank you.

Jim:

Yeah, at CareMore and Anthem, we sort of have gone through as a lot of companies have, varying evolution. CareMore started as a provider group 26 years ago began to take on risk with payers, turned into a health plan, a full risk entity itself, sold the Anthem and in varying markets now, with varying population, we're fully at risk, we're capitated, we do still have some fee for service based solutions. And I think what we would see in all of those different varying environments, is that we're really able to be our best self when we're fully at risk. When we're able to make sure that the networks that we support, the patients that we support are maximizing the dollars that the federal government funds us. We sort of have to dilute our best self if we're in a different financial arrangement. And then not just why it's important to us, but why we feel it's important to our network partners is, at a full risk capability standpoint, it really allows us to share in savings that we feel like we earned together. These are by reducing avoidable waste and keeping the members' perspectives, goals of life, and true informed consent at the forefront. And if we do that together, it allows us to be fully at risk and our providers to be at various levels of upside or shared savings or quality bonusing or risk entities themselves.

Diane:

Mm-hmm (affirmative), thank you.

Scott:

At Ascension, we may be a little bit unique when we think about risk, we're the largest Catholic healthcare provider in the country. We operate 147 acute hospitals. We're a large senior living and SNF operator. We have joint venture partnerships within home health and the hospice space and we have other financial alignments within every level of post acute care in addition to having health plan and having our own medical group. So we look at risk as a large opportunity to better engage with the infrastructure and assets that we do have in place already and truth be told, there's a lot of opportunity for us here, which is going to take into this discussion we'll get into a lot of the nuts and bolts that are really the key drivers that you need to put together in order to make these types of arrangements successful. But we really look at it as it's a large opportunity as we move down towards a fee for value model going towards the future.

Scott:

And I would say that we're probably the earliest in the journey. Memorial Hermon, we provide a vast majority of the healthcare services in the greater Houston area. And Houston has lived in the fee for service and still maximizes the fee for service. So the vast majority of the physician providers are still pretty fee for service so we're going through the culture change as a city. We really believe that risk is for us where it's all going to be in the next couple of years. 18% of our patient population is unfunded so we're fully at risk effectively for the city of Houston. It's the most underinsured major metropolitan region in the country. So we've started, we got originally all into upside risks so we were learning to build the infrastructure but now the true opportunity is in those arrangements where there is upside and downside risks. The biggest challenges for us are how do you align the physician payment model, which is not adapting at the same rate as the federal government pressure on large healthcare providers.

Diane:

Absolutely, I think that's a great point as well that we wanted to make today because when we talked at the general session, I think we were talking about why now and what's really causing this to change. And I think one of the things really important to all of us is understanding our individual markets and I think they made that point this morning as well. But just your point about the amount of fee for service in your market. So I'm from Pennsylvania and we're one of the fifth highest concentrations of managed care in the United States and the gentleman that spoke this morning, Dan Lynn, who's from Minnesota, they probably have 70% managed care penetration in this area. So that significantly changes your perspective and how you act within your market definitely. So I think it's always a good level setting that anything we talk about, I think they made that point this morning as well, it's very particular to your market and what's going on there. And what may work in one and sound like a great idea to your point may have some real challenges to do that.

Diane:

Scott, I want to go back to what you were saying about the key metrics and whether it goes over to the physician side and what not but when we think about the fact that we may have fee for service, we may have Med advantage. How about the key metrics? Are they the same no matter what you're dealing with and what have you seen in that area?

Scott:

I think that when we think about metrics and you think about outcomes, you've got to boil it down to what are our risk and value programs designed to do and that's to manage patients to success into the

community at the lowest total cost of care. There's a few things that are really key drivers to that. One is that second acute stay. So patients that show back to an inpatient for a second acute for any reason. Specifically, for a potentially an avoidable reason and the other one is at the site of discharge, are we getting patients to the lowest cost most clinically appropriate setting of care. So from a measure standpoint, we look at things like readmission rates but specifically, we stratify that to risk adjusted readmission rates and really try to isolate ones that are potentially avoidable and that gets more into the operational components and integration. We look at ED utilization. So how many patients are sending back to our ERs for ob stays. It's not the same cost but it is a cost to the system overall. Beyond that, there's a number of different measures you can look to from a quality standpoint and a cost standpoint. A lot of them get down to connectivity though. There's some operational components to this that really provide a lot of value and really drive this equation the right way. That's making sure that you have the right people clinically talking to the right people in an ACO type model.

Diane:

Right, Matthew, you have.

Matthew:

I just want to add from a physician practice standpoint, one of the things that we're seeing from our providers as we're going through that culture change, is everybody is bringing the docs measures and they're all slightly different. So the docs don't know what to do at the front line and it's really hard to drive value. So what we really started to emphasize is these are your five priorities or three priorities for the next year. Docs, this is how we're going to work on that. And then you move up the chain and start out with whatever's the easiest. But our initial foray into multiple ACOs, all the measurements were different and the docs didn't know what to do. If you think about the provider sitting in front of the patient, you want them to do the same thing every time consistently, individualized to the patient. But if they go, "Is this a this payer vs that?" it fragments the care in ways that's pretty challenging to the doc. So I would advocate simple, consistent across all your plans, so the docs can get some traction.

Diane:

Skelly, I would imagine in your role, you have some perspective on both of those things.

Skelly:

I do and in hearing you guys talk, it's all about the standardization. It's increasing that efficiency, reducing that waste. And really how we look at measurement is those broad outcomes, which are great, those are fantastic when you're an executive or a regional director and we need to measure the overall health. But really what's important on a day to day basis are those process measures. So really understanding at the core level of the facility or the housing or whatever it might be, the home health entity, they're very into all across.

Skelly:

Readmissions are one big one that for sure we all speak but then there's those process measures, meaning, I'll just take one simple one that we struggle with, did the orders come from the hospital because we measure each other and that's another component. When you're in this together, it's not the health plan measuring the organizational provider. That doesn't work. I also need the organizational provider to be measuring us and to force us to look in the mirror and say, "Well guess what. We actually about one out of every ten times a patient comes to us, we don't get the orders and they're not right, et

cetera et cetera." That's a process measure that ultimately shows up in readmission rates, shows up in overall costs of care. And I would just say kind of the partnership is the key component to all of that, is are we having daily accountability, weekly accountability, monthly, quarterly, broadly. Yeah, it's a deep investment but one, especially when you're gain sharing and when you're risk sharing, that is so worth the investment because the outcomes and then we all succeed and mostly, the patient succeeds.

Diane:

Absolutely.

Diane:

I think we're going to move into the scenario that we have developed and get a little bit deeper on that subject.

Bill:

Yeah, so to kind of dive in on all that, we did develop a scenario that kind of goes into gain sharing. I'll share it with you here and we have follow up questions after that. Really, the scenario includes a payer and a health system are discussing going into a risk contract with one another. The health system sees this as a great opportunity but it knows it has limited control over the patients in the post acute care space. Therefore, the system wants to gain share with the physicians, as many of them actually belong to this system. Again, that would keep financials internal and the return would stay within the system itself. Senior housing executives see this and they want a piece of these gain sharing dollars. They want a piece of that pie. They're seeing the higher acuity patients, their staff is working with these patients, and they're seeing that decrease reimbursement due to shorter lengths of stay down the road. Specifically, they want to cut in the improvement of SNF spene per episode. So that's what we're really looking at here. So I guess I kind of open this up to you guys. Just looking at this, what would your argument be for either disagreeing or agreeing with that gain sharing with a facility and would you push the dollars that are saved towards the physician as the key driver behind this or towards that facility and that multidisciplinary team?

Bill:

I'll start with you.

Matthew:

I believe the only way we're going to do this successfully is as a team sport and everybody who contributes to the success has to be able to see benefit in their part of participation of that. We're starting to go back to a lot of the vendors that are coming to us with we would like to put this technological solution. We go, "Are you willing to go at risk with us because that's where everything's headed." So I believe that if you can come up with an arrangement that made sense and didn't dilute the dollars out too small, insignificant to the individuals up front, everybody should be at risk.

Bill:

And do you feel like we dilute those dollars? Because when you really get to, let's call it a program, and you’re gonna get x amount, when you divide that across, let's say 30, 35 facilities within your network, and then you could be even dividing it again between the physician and the facility itself, very easy to dilute those dollars. So how do you avoid that or combat that? There's a pretty good chance in the beginning of the program that's going to happen.

Matt:

Yeah, for us, there's six healthcare systems in greater Houston. We have the largest market share but not by much. And it comes down to covered lives. It comes down to the pool and your ability to do that. And that's where I think Kaiser and Intermount and some of those folks who have really gone to scale and we're early in that journey. We're about 600,000 covered lives, I would say. But we need to double or triple that to be able to have the financial wherewithal to truly impact both providers and the facilities. So it's scale, I think.

Scott:

I would definitely agree with Matt on that with maybe a slight deviation. So it is absolutely a team sport. There you have a bunch of elements really all factoring in this equation. I saw one of the talks yesterday talked about you have payers, you have providers, you have physicians, you add in government regulation. All those forces all kind of factor into the equation. I would say our lens is maybe a little bit unique amongst the group that we have on the panel. We own a lot of those elements but we don't uniformly own them in each market. So I would say back to the question of the risk sharing, that would be a situational decision. And that's not a cop out answer. It's a multi-faceted question where you have either physician ownership alignments or you have outside physician alignment. The one thing I will say is that I do believe the health system is better positioned to pull all of those groups together to coordinate that care and to impact that equation on reducing total cost.

Bill:

When you look at down the road, do you see more health systems kind of taking over and owning that full continuum of care for the reasons we were just kind of talking about?

Scott:

You see it in pieces. But you also see health systems that are going to hold out for fee for service until the last drop. So I think you probably have the dichotomy of both ends of that spectrum. We firmly believe that in a couple of years, the landscape is not going to look like it is today. So we're on a journey. We're on a five year journey at Ascension, moving towards positioning ourselves strategically to be ready for a fee for value environment in 2025.

Bill:

Thank you. And then Jim, from the [inaudible] perspective, what would you rather see happen out there in the healthcare world?

Jim:

Yeah, so, I'll frame up my answer first. I think that so often times, when we talk about risk, we get caught up in the upside of risk but let's not forget that there's a downside to risk. So many of the answers that you'll probably hear on this panel and then today, are all about shared savings. Well, what about if there's not shared savings? So you have to be willing to get your hands dirty, take some losses, learn and apply those losses. Most of our successful markets today, we frankly have struggled mightily for years at times in which to get to scale or in which to get to a shared savings or find the right system. And we've gotten there but we've gotten there with trial and error. And so that was the first thing that I wanted to make sure that I said. And I'm going to give some strong opinions on this exact example based on experience. And our experience has been that the health system risk deals that we've done have done a great job of driving membership. They have not done a great job at driving down avoidable costs.

Jim:

My opinion in supporting this industry for 13 years, in the exact scenario that was given, I would expect the health system to reimburse the SNFs more appropriately than the payer. I do believe that the community, the SNF in this case, the sub acute network, I would narrow and I would work as hard as I could, change management or whatever you want to call it, with my health system case managers, with the hospitalist teams to be angling members towards SNFs that are truly adding value back into this overarching agreement. That way we're limiting the risk of leakage and those instances where we're not getting the most out of the referral or admission or whatever you want to call it.

Jim:

In this exact example, I would give, probably not risk to a SNF, because again, risk, upside, downside, percent of premium, I would probably do some sort of shared savings arrangement or some sort of at least value based bonusing. So that might look, to get real tactical, that might look like I'll reimburse the skilled nursing facility maybe more than 100% of PDPM or maybe more than an equivalent of that on a per diem if they take a member quickly, get that member out of an avoidable higher cost setting, and move them to a more appropriate setting and if you take that patient, within, whatever it is, a couple of hours of my referral, you get some upside. If you take the patient evening or weekend, you get something else. If you discharge within a certain appropriate amount of time, you get something else.

Jim:

And that really does work with volume. It wouldn't work on a couple of isolated cases but the point I'm trying to make is that when you talk about risk, there's downside. When you talk about risk, there's only so much of premium to go around. So I think that skilled nursing environments need to get comfortable talking about shared savings arrangements and talking about even just quality based bonusing. Because dollars are still dollars and there's probably more ways to skin the cat and an easier path forward with a shorter runway to start doing something like that and then your outcomes are going to speak for themselves.

Diane:

I think it's really interesting too with some of the metrics that you just indicated that you would bonus skilled nursing on are very different than what we hear traditionally and it makes me think about some comments that are being made about knowing what you do well and what you don't do well and I think that those indicators that you just said are things that skilled nursing operators can do well and it fits in with that and they don't perhaps have to go this far, they can start with some baby steps as well along the way.

Matthew:

The scenario in the first talk where the gentleman talked about stabilizing in place, that's the behavior you want to reward. That sick patient, you avoid the ED, you avoid the admission, two days there, where the inefficiency sometimes in the acute stay, that would be a three and a half to four day stay. Manage it locally and that's the behavior you truly want to reward both from the physician standpoint and the facility standpoint.

Scott:

And one quick comment too to Dr. Harbison's point, if the health system is the one that is at the base sort of arrangement with the payer, they probably have a lot better ability to financially incent their SNF that's in the community than me. My metrics might not be as powerful or practical in fact. So why not avoid what you commented on, which was too many goals from varying lenses and

perspectives when I could allow the employer to really just do that and motivate a behavior better than I could.

Bill:

And Scott, you're in a very unique position here.

Skelly:

Yeah, and so it's a hard conversation for Kaiser Permanente. We are a prepayment model so we have the dollar right up front but we own everything. Every bit of the care. We don't get any more we don't get any less. It is what it is. But I can tell you this, we have been successful because we have done it together. We didn't do it just as the health plan, right as the payer, we did it together with the hospital entity and our provider partner entity. We could never have done what we have done and accomplished what we have accomplished without kind of the trio.

Skelly:

I will tell you a story where about three years ago, we embarked upon kind of a SNF provider, preferred provider journey. And when we did this, we had really rigorous conversations with our SNF providers to say what does this look like because what was happening was we were getting backlogged in the hospital. We had, you guys are probably very familiar with avoidable days, so you have stable patients, sitting in hospitals that have no medical acute needs. They're sitting in the hospital. So we said what does this look like, what do we need to do on our end so that we're working together and not against each other? Because we know that you have the beds, we just obviously aren't the best payer.

Skelly:

So really, what we did was instead of developing kind of a complicated gain sharing program, what we really did was we reimbursed them and the contracts look very very different in northern California than they did three years ago. And if anyone in the room is from northern California, you can attest. I mean, they look very very different. And so what we saw was about an 85% drop in avoidable days because now they were incentivized to get the patient out of the hospital no matter who the patient was. It didn't matter what that patient looked like, because we were true partners.

Skelly:

We're also very different because we have physicians and case managers 5 days a week sitting in the skilled nursing facility, managing our patient population. So we're a little bit different. But again, from 5 pm at night until 9 am the next morning and on most weekends, we're not there. So we really needed that partnership to come to fruition. And it did. Our quality measures of all types went up. Our process measures went up. We didn't have patients sitting in the hospital. And I guess what I will say is when we were holding onto the money, was that really working for us? No. Was it really working for the member? No. Really the right thing to do was to share. Was to figure it out among all of us because they are us. I never use the word vendor. I can't stand that word and if any of my partners use the word vendor, not these partners but my partners back home, it is an immediate conversation that these are our partners. These are organizational providers that are partnered with Kaiser Permanente to serve our members. So I guess just that story in and of itself was just a great success of partnering and what it can do to share.

Bill:

I think when you look at partners, it is that team work that we've continued to talk about here. And Scott, from your perspective, when you look at a skilled nursing operator or a group of skilled nursing facilities in a network, what are the tools that you guys need to be successful? Because it's not fair for the health system of the payer to simply say, "Hey we need to avoid these readmissions. We need to decrease this length of stay." What tool do you need in your back pocket to really improve upon this instead ofsomeone kind of beating you over the head at the end of the day?

Scott:

Sure. At first, I want to show a shout out to Skelly for the vendor versus provider conversation. I've suffered through many of those at this point. We see it the same way. It's these are our partners. These are the narrow group of folks that we need to closely collaborate with. We definitely are on the same wavelength there. From the tool standpoint, there's a few. So we break it up. Really, when we look at how we manage our post acute networks and the tools that we look at, we kind of break it up into two different buckets. One is real time patient alerting for transitional care coordinating so that way we know where our patients are in and out of network. We can get intelligent changes of status on them so that way we know when we have to put touch so we can essentially manage by exception. The other is really network performance management. So getting back into the measures conversation, so what measures are we utilizing to give our providers a score card and coming back to the table and focused on that long term partner continuous improvement. So performance management is a part of that.

Scott:

So the tools that we look at are, Remedy's a good example. So we have a partnership with Remedy and we use Episode Connect. So it is a platform that can connect our acute EHRs to the post acute EMRs and give us that longitudinal record of that patient across care settings because as most of us know, post acute is just a highly fractured environment. Making sure that the right people get the right information at the right time to make an actionable clinical decision. That's what's most important.

Scott:

Decision support at the discharge planning site. That's one, going back to the Remedy. It's the Carl(?) tool. It's supporting case management and does this patient need to go an in patient rehab or can this patient go to a scaled nursing facility? Or if it's a skilled nursing facility, can this patient actually go to home health? So it's the lowest cost, clinically appropriate, site of care. We're looking at it from the standpoint of the journey really kind of goes towards making home the next site of care. And underneath that, you have the things like hospital home models. But that is one of the tougher ones to solve for is really making sure that they get the right information at the time they need it.

Bill:

And I think kind of we talked about this last night at dinner a little bit. We talked about more patients going home and really delivering care in the home. And you guys look at it from a para perspective, post acute and a provider perspective, what tools are needed and who should be responsible for getting those tools into the home or an assisted learning facility. Any of your communities, whatever it may be, who should be responsible for that and do we see that as kind of the future is really where we're going in this value based continuum?

Scott:

I mean from our standpoint we see that on who is best positioned to control the coordination of the risk bearing entities or the network of aligned providers. We're looking to develop that internally within the health system and spreading that out through our multiple ACO groups in each of our markets. But there's a partnership to that, right, there's two sides, it's a bi-directional communication that needs to happen on a consistent basis for it to truly be effective.

Bill: And how do you see that, from the provider side

Matthew:

I believe from a provider side, because population health, particularly in Houston falls on us as the provider, we need to build those capabilities and capacity within all the various settings. And that's going to come through partnership because we're not going to be able to do it by ourselves. And to go to your question, we're opposite of your managed care. We're 70-75% fee for service and 25% so we're still trying to overcome that. So as an organization pivoting in a couple of different ways. I'm a hospitalist. I used to draw every care pathway from the moment they saw me, which is absolutely incorrect. I have evolved. My wife is an adult endocrinologist and she owns her own practice. And my wife should tell me how to manage diabetes in the hospital because that type of care coordination, if we do this well, a patient's going to see me one, maybe two days out of 700 if we do it well. And they're going to see her once a month and communicate with her a lot. So sorry, I digress.

Matthew:

I think we have to build that capability, particularly supporting the post acute facilities. You won't achieve the success and those individual entities won't be able to do that on their own without partnership. And that partnership comes with support and that's technological and skill set and things like that and also the volume support. Because it's hard for us to ask folks to make the investment without providing the volume in which to sustain that investment.

Diane:

I'm wondering, Skelly, so on that thinking about all of the different buckets that Kaiser is in, if I was an operator sitting here, I would wonder, again getting back to the competition versus collaboration that we're talking about here, you talked a little bit about how, and I think Jim did too, this has been a long journey. This is not like overnight we woke up and we did this. But could you talk a little bit about knowing what it is you do well in the different buckets that you're in and who gets to own that patient as Matthew said, what's the right area for that to be in and how do you manage that?

Skelly:

Well first, I think we'll all agree that the post acute space looks so different. It's just a different animal than, I mean I have a nursing background, so I was a nurse, I'm not going to say how many years ago. And the patients that were going into the post acute space, those patients are absolutely going home. I feel a little bit of a broken record saying this but think about it. Think about 10, 12 years ago. These patients don't look like they did before. So really, when we think about, and we think about reimbursement and we think about the cost of the patient, and we think about in 10 years, we're going to have 40% more of our aging population over 65. We really do need partners that are willing to have rigorous, deep, innovative conversations about fixing it together. And what that looks like is ultimately, we're a huge system so we have to have preferred providers. We cannot partner with everyone.

Skelly:

So my advice, I guess a little bit, if I were to be speaking to post acute entities that want to partner with big payer systems would be number one, keep your high quality high. If you have high quality keep it there because even getting a seat at those tables, it's going to be really challenging if you don't have high quality already. You can't expect to come to the table and say, "Well if we did this, if we gain shared in this way, then we can bring the quality." We already have to have it there. And actually, we have had to sustain it for quite some time. Bring data. Have lots of data. I will tell you, it speaks volume. If your quality is high and you understand your performance, that speaks volume.

Skelly:

And then be willing, here's a big one, this year, we actually had the first health information exchange, bidirectional data, between Kaiser Permanente, we call it KP Health Connect, that's our EMR, and Point Click Care in about five facilities in northern California. It was so monumental that now my physician partners can see the data in Point Click Care and the point, right it feeds. It's not perfect. I'm not going to say it's perfect. But imagine, we'd never had that before. And we sat and sat and we talked about it and talked about it. And I'll tell you what it took. It took a few providers sitting on a teams, WebX, because everybody has something, and we sat there for hours and hours and hours, week after week after week, figuring out which data sets. Was it going to be a CCD or was it going to be an API or what did that look like? Not every provider is willing to do that. And that was frustrating as a payer to see that because we knew that we needed to go there but we also need the experts and we're not the experts in that space. My providers are but they're a provider expert, they're not a SNF operator and we really needed them to come to the table.

Skelly:

So those would be a few of the kind of larger components that we're looking for.

Diane:

Do you have anything you've seen in that regard to add to Skelly's comments?

Jim:

Related to the question of what we're sort of excelling in and sort of the build versus buy concept?

Diane:

Mm-hmm (affirmative). Right.

Jim:

What I think CareMore has done, and maybe this will tie into some of that last question too, is going back to the home, care being delivered in the home, and certainly the build versus buy, we've tried to innovate and develop where gaps of care exist.

Diane:

Yeah.

Jim:

And that's really sort of a mantra of CareMore's all along. We want primary care to be great at primary care. We want skilled nursing post acute communities to be great at that. And one more tip I would say is, everybody seems to kind of think that it's sexy to meet some sort of unique need. We actually find it quite opposite. It's important to have event facility, sure. It's important to have a behavioral health wing, sure. But I get more pings and emails about we're now a center of excellence for this. Everybody's trying to make themselves so unique when what's unique to me is somebody that just does the very basic things really well and communicates well.

Jim:

When CareMore looks at home health and home care and all these different solutions, trying to support a patient and fill gaps of care, we're developing things like hospital at home programs where we can't build it and don't have the scale, we're looking for partners to optimize network. Medicare's got this great and horrible two word phrase that's called Network Adequacy. I will assure none of you, it's not adequate. What it basically means is that you've shown Medicare that time, distance, and volume, you have enough contractors to meet the need of your county.

Jim:

But the reality is that so many needs are home based now. And so we've spent a lot more time away from adequacy and more towards optimization of a network. Because we can't do it ourselves and we shouldn't try. But things like finding the right mobile radiology company, finding the right home health company, finding the right mobile lab company. There's so many great mobile solutions these days, both from our end, trying to best manage a patient in their own home, as well as from your end if you're sitting in the building here and you're representing a post acute or even an assisted living operator. How can we make sure that we're padding, us together and you, padding these members with the support they need on site? Because we still see so many avoidable folks being, 9-1-1, sent to the ER, for things that there are technical and capable teams, partners, prepared to support. Couple of things we've learned.

Diane:

Bill, can I tweak our scenario?

Bill:

100%.

Diane:

Actually, I'm not going to tweak it I'm going to blow it up for a second.

Bill:

Go for it.

Diane:

So when I think about the work that we do, as you just talked about, some of the low hanging fruit right now has been around skilled nursing and of course, terminology wise when we're talking here today, about senior living providers, my mind instantly goes to everything senior living. So we've talked mostly about care settings right now. But I really think that as we continue to look at, particularly in our organization, why would people want to come to a continuing care retirement community in the future?

Diane:

What about Ann Tomlinson Innovations just released a study yesterday showing that I think 30% of seniors living in senior housing are managed Medicare. So all of a sudden, I've got a concentration of people. So whether it's fee for service or med advantage, I've got a lot of people in my buildings that you probably would be interested in knowing more about. And these are people, by the way, that really trust us because we work where they live. And so, as senior living providers, I think we have a real platform, and we've talked about this here at the conference, where we should be able to leverage that in a space

where we really have some expertise in some nontraditional areas. And so, you're all large organizations and a lot of times these places are small places in the middle of that. Any thoughts on how do you engage into a big complicated system to really demonstrate to any of you what the benefit is of having all these seniors live in one place and how might I interact with you. So I'll throw that out for whoever. You want to?

Skelly:

Oh my goodness. Yeah, so the senior living space is for us, such an amazing opportunity. We have for so long focused on SNF and home health and institutionalized settings. And I think by default, so many of our patients just get defaulted to custodial SNF. And so as we see, right now we're up against major capacity issues. We're now having, we have the partnerships, they're willing to take the patients, but they truly don't have the capacity. So it only makes sense for us now to build the partnerships that we have with our home health providers and our sniff providers and our hospice providers with our senior living providers.

Skelly:

We do have home based models of care and my goodness, does it make it so much easier on our provider partners when they can go to a senior living environment where and see 25 patients versus having to go from home to home to home to home to home. I think where we struggle is with the payer for some of these patients but by golly, we're, let's be clear, we're paying for them in other settings at times and then trying to figure it out. Why not build that partnership with our assisted living facilities? And we need to and that's a big reason for why I'm here. So would love to meet any northern California assisted living providers and understand how we can partner differently and get innovative because the time is now. Because the aging population is growing and they're getting sicker and they need these living spaces. They're going to be there. So how do we come together to service these patients together.

Matthew:

It's almost like a direct to employer model. It's just a nontraditional employer but we're embedding clinics with our large corporations in Houston and it's a coalescent of a group of people that we want to keep well. And you deploy your resources in order to keep them well and not use the acute unless it's absolutely necessary. It's an interesting evolution.

Diane:

And I think in some conversation yesterday we were talking about the fact that linking with a senior living provider makes the physician's job so much easier in the first place.

Matthew:

Most definitely.

Diane:

And I think they said it this morning. The payer would love to have their eyes on their clients 24/7 like we do. So there’s a real value proposition to that. And I think to your point, Skelly, it would take different ways of gain sharing or it's going to take something different than where we're at today.

Scott:

I would mention that we are similarly investing in the strategy that Dr. Harbison mentioned, which is when economies of scale do exist, even in an assisted living or CCRC type environment, we will lease clinic space. And the number that ATI came out with last night is an important one because 30% to us is believe it or not, kind of around that approximation where we've actually seen it start make sense, 30% of eligibility. So if it's 100 bed sort of assisted living community, then anything less than that, not only is it challenging for the health plan, the payer, the provider to support, but it also is very challenging for that community to differentiate between I treat my Kaiser, Anthem, Memorial Hermon patients like this versus the control group, which might still be fee for service.

Matthew:

Right.

:

And so I guess there's sort of some change management built in here too and I think you're organizationally feeling a little of that right now is with all the different payment models out there, what is that magic number where you can actually see and differentiate both the results and the member experience.

Jim:

And you've got to also think, if you're in the audience and you're thinking about as an assisted living, CCRC or even skilled nursing component with large custodial membership, with the MA plan that I'm seeking to do business with, what does their product portfolio look like for the member? And I say that because there's great payers out there that do great work but their forte is not necessarily supporting their senior that gets to 80, 90 years old with seven comorbid conditions and requires a ton of oversight. In fact, I would tell you that until recently, there have been a lot of Medicare Advantage plans that almost created benefit portfolios for the 65 year old marathon runner and how many of those live in your communities? And it would unintentionally encourage a senior to almost disenroll back to a fee for service Medicare because more providers were ready to take on that challenge.

Jim:

So you look across the spectrum at some MA companies and there's even MA companies, ours included, that are leaning in heavily on the supplemental benefit expansion. The same way that we build networks for skilled nursing, which is a very standard setting that's reimbursable, we now have an assisted living network that we built in two states because we have a respite benefit where we've said as an organization that there are members that are sitting in a SNF even that don't need to be there or sitting in a hospital that don't need to be there. So there is sort of a membership exchange opportunity I think. And I hate to think about members and patients in the way of currency but there's a path forward where I think it's not just a one way street.

Jim:

We as a payer are sending patients to assisted living today. We are paying for patients to live in assisted living today. Is it rare? Yes. Is it brand new? Yes. Is there data on it? Not necessarily to support it yet but I think we're onto something and I think Medicare believes in that strategy and that direction. So it's okay if you're in the audience here and you're thinking, there's so many MA providers in my market, how wouldI even go about finding somebody to talk to? And then once we talk to them, like there is research that can be done and you should find one or two that make more sense that are more available, more accessible and are innovating in this space.

Matthew:

My other challenge just with all the talent on the podium is really, we still talk about all of this at the provider level but we have not addressed how we pay large health systems and how we pay the docs. Again, my wife runs her own practice. She's a solo practitioner. 100% of her overhead is paid for by fee for service and we hold out these value based payments, which are ill defined, ill timed, in somewhere far in the future and it's hard for me to go to her and say, "I want you to reduce your overall patient volume, focus on value, because maybe a year from now you might get some money."

Matthew:

And it's a fascinating dinner conversation but until we also start to figure out how to address the fee for service at the doc level, because they've got to pay their overhead. And Texas is a corporate practice medicine state. We can't employ docs as a health care system, similar to California, I believe. I think California, Florida, and Texas. But because fee for service has driven our market, almost 100% of our docs are fee for service. And I think that's why we haven't been able to achieve our ACO output is because we can't figure out how to get that money to the docs up front so they can change their practice patterns. And so I would welcome any insight to help us solve that both on a personal basis and a corporation basis.

Diane:

Any insight?

Skelly:

Here's what I would say. I would say for sure, with us, we figured it out because we had those same conversations with our provider partners that we did similar to the SNF partners. And we said, "What does that reimbursement look like?" So we do, we have a seat at the table. And it's an annual conversation but it's projected 3-5 years out and we say, "What does it look like?" We know that we are a pre-payment model. Knowing that, here's where we're all very transparent. So when you look at the financials and you look at it, you know what's coming in, you know how much everything costs, you know how many docs you need, we all know that. So the conversations are all about value. It's not a conversation about how do we do more so that we can get reimbursed more. The conversations, we were talking about it yesterday. When you have two different payers and you have two different health plan models and one is like us and saying, "Hey, the Medicare patient population is tough for us. It's really tough. We have a big gap there. How do we all solve it together?" Whereas, another payer is going to say, "Hey, actually we do pretty well on the Medicare patient population."

Skelly:

It's a totally different conversation. And so I think that's how Kaiser worked it out but again, in every conversation, somebody's holding onto the dollars and I love that this is why we engaged in BPCI, this is why CMMI came to fruition, this is why we continue all these value based conversations because ultimately, this great work that we're doing should not service this one person holding all of the dollars. It has to service everyone. And ultimately, it has to service us. It's us. We're all going to be in there. We're going to be all in that patient population that we're talking about soon. I know that's not super helpful but I guess I would just say, at some point it has to happen. We have to have those conversations or else nobody wins. You're going to get all these dollars but because of all of the inefficiency and waste, it's all just being spent. So there's no value attributed to it.

Matthew:

One of our docs went to Kaiser and a lot of it comes down to data as well. He knows utilization factor and down to the CT for. And we just don't have that data yet to be able to. And I think it's some difficult conversations with some providers who you are no longer part of our network. And we have not traditionally done that very well.

Scott:

There's the data. You need to have data to partner in any capacity but like we've been talking about, it comes down to it is a team sport. The AL conversation, specifically, is an interesting one because it's an area that I would say most health systems really haven't engaged there down to that level and that's really for us, that's the next frontier because when you talk about the other component that's really valuable here, it's that operational connectivity. That continuum of care is really, truly what is impactful and important. So having your physicians integrated, knowing where your patients are, having providers, being able to feed that back and having that continuous feedback loop and that focus on the longterm partnership. AL really, senior care hasn't really been a part of that equation but frankly, as we all know, there are residents in your buildings that are getting healthcare they are part of all these plans. Is there a mechanism in place? Are you working with your local health systems? Do you understand where they have narrow align networks and are there opportunities for engagement there.

Bill:

And I think that leads us really to that last question that we have is we talk about that next frontier. You've talked about strategy 2025. For all the folks in the room here, what is that biggest opportunity from your perspectives over the course of the next five years? What are we looking at? Where do they have to be in five years based on the different perspectives we've talked about today and where do you think we need to go?

Scott:

Home.

Scott:

There's studies out there that show a large, large percentage of population polled want their care in the home today. And that's likely to only grow as we get down the road. So models that provide the care needed in the lower cost setting, which often is home. So it's those hospital at home models, the respite carpet that Jim talked about, that's a great example, that's innovative.

Bill:

Your perspective.

Matthew:

So I think it's alignment. It's alignment of the payment or the reimbursement or the rewards, however we want to use the term, and then the most effective technique that I've had is put your mom in the bed and if you can look at how you would want your mother to be cared for in that scenario, that's the healthcare we're supposed to be designing. And we tend to look at it at the macro level and we talk about patients sort of as widgets, we think of at a population level. But man, every single doc who says I don't need to use order sets or you're telling me how to practice medicine. I'm like, "If that was your mom in

the bed, how would you do it?" And they all have the exact same answer for sepsis. They won't use the order set but they'll do it if it's their mom. So I think that's the biggest opportunity for us is to continue to go back to your loved one and manage them through the system and help solve the problem that's in front of you using that as your true North and we'll do really well stuff. We'll do really good stuff.

Diane:

And I think when you think about it from a senior living provider, even if you're non medical, whatever, you see everyday, those things that happen to people that really could create better care. It's that coordination, it's getting transportation, all of those different things. I know when we look at affordable housing, and we continue, even in ACO markets and everything, we just continue to see the daily stuff that happens to people. And to your point, if you look at it like it's your mom and many of these people don't have family to help them navigate these things.

Matthew:

Yeah, the gentleman in the first session talked about transportation as being one of the biggest drivers. Transportation and meals. You don't want your mom to be hungry and if your mom wants to go out with her friends, you want to figure out how she can do that. That's what we should be designing.

Bill:

Jim, from your perspective?

Jim:

In five years, I sure hope that Dr. Harbison has better dinner conversations with his wife.

Matthew:

Do we have a story for you.

Jim:

Maybe we can talk after. Maybe there's some capitation models of prospective payment stuff that we can put an end to those dinner conversations.

Jim:

I think that one, we just have to simplify things. I think that so many of our problems, and we were guilty of this even in a morning session yesterday, where we spend what was an hour and 45 minutes and an hour and 35, we talked about all of the problems and only ten minutes talking about the simple solutions. And somebody brought up by the end of that, let's not let perfect get in the way of good enough. So I think that that's one thing in the next five years that companies have to start to do is really just distill down your issues into those top two or three, distill down those physician goals into the top two or three and let's make it more achievable and let's work towards those.

Jim:

We talked a lot about expanding opportunities, expanding network. But you brought up a great point, narrowing network. I think we need to know when to cut bait. I think that it's okay for us to try something innovative or try a relationship and if we either can't align on the key performance indicators, we can't align on what good care looks like, and it's not mutually benefiting both parties, it's okay to say,

"Okay, we tried. Let's seek other options elsewhere." And they don't even have to be negative conversations. You're probably ending up putting that other partner in a sense of relief, maybe even. Because maybe there's a better partner out there for them too.

Jim:

I think that those would probably be my couple.

Bill:

Skelly?

Skelly:

Oh, goodness. All right. So I think we need to focus on the long view care and what I mean by that is a longitudinal plan of care, one that spans the hospital, the continuum, adult family medicine, I don't care where they are, that longitudinal plan so that we're not siloed out, so that we're not having separate new conversations every single time we see a patient no matter where they are.

Skelly:

I also think that I put in here we better leverage technology because our aging population is screaming that they want to be home but they are sick. They are super sick. So scaling that model is going to be really tough. It's going to be really tough. So how we're going to scale it is through technology. So deep investment in technology without a doubt.

Skelly:

And then the last one I will say is we call it supportive care services at Kaiser Permanente. It's those palliative care conversations, advanced health care conversations. People are scared to talk about death and dying and we've got a very very sick, frail aging population and we need to know what their wishes are. It doesn't mean that we need to be Dr. Death. It means that we need to have the conversation to know what their wishes are so that their families can get comfortable when they can't have those conversations with the patient, we have it with the family and they're very clear on their wishes.

Skelly:

That's what I would say.

Bill:

All very good, very valid.

Diane:

One of the things that I think about is in this as well is we've been talking about it being a team sport, data being very important. I think one of the others, and I think one of the others, and Skelly, I think about the work that you and I talked about yesterday about the health information exchange, and where technology fits into all of this. Because it seems like there needs to be a sea change as well in terms of being able to see people differently. So as we're talking with our manage care providers and trying to move things into the continuum, into affordable housing, into independent living, our managed care providers can't really see their people in our setting. So they can't see that all of these people might be in ten of our communities

or their high risk people might be in this location. And of course, we can't see it because we're not privy to that information.

Diane:

So I think that another thing just in terms of where the future needs to go, is somehow, getting that information where it needs to be because I think as senior living providers, we have a very different view of what happens the 360 days that the person's not in the hospital and just little things that could really improve them. And/or if we knew a little bit more about their healthcare needs, the intersection might be there. So I don't know that that's a question but maybe perhaps, a statement and I don't know if that-

Scott:

Well yeah, let me add onto that technology conversation because I absolutely agree with you there. We're in the middle of that sort of buy versus build strategy session right now. And I'll throw out a few names that you may or may not hear. So you have the Remedy, EpsoConnects, you have Patient Pings, you have Post Acute Analytics, you have Repaired Healths. These are platforms that ideally you want to solve multiple problems for you that give you that visibility where you have high functioning health information exchanges, that's great. But most major markets don't. If they do have it, largely, they're ineffective for a variety of reasons. So it's focusing on investments in technology that expand that longitudinal record that where you can see your patients across the fractured spectrum. Systems that can pull in the payers that can reduce problems like authorization waiting periods from managed care, get patients out of the hospital quicker for those avoidable days. There's a lot that technology can do for you but the unfortunate reality you have to overcome a highly fractured environment, even within a health system. And that's the frontier that we're on right now.

Diane:

Yeah, it's true. Absolutely.

Bill:

We have about 10 minutes or so for Q and A.

Diane:

Yeah.

Bill:

So I guess, anybody in the audience have any questions?

Speaker 7:

Hi, I'm from Mexico so this is out of left field. I heard you say at the end that the common denominator is the client, is our mom and I know everything is money. And I see this gentleman right there. It's amazing what he's doing but everything you wrote, it's about team sports, it's about cooperation, it's about team players. But I think that we concur that the denominator is us. We will eventually be our own clients. Are you willing to team across borders? Are you willing to look at cross border opportunities for cost efficiencies, for senior living, for healthcare to provide your customers, us, the solution for them to choose maybe to live at a coastal area in Mexico? And say, "You know what, I would

love to live my last years in Los Cabos and have the health insurance and have the services." That's my question.

Diane:

Man you think our regular siloes are bad.

Scott:

Yeah.

Skelly:

I like it.

Jim:

Just threw another one in there.

Matthew:

So right now, I wouldn't say that living on the beach in Los Cabos but I think a lot of the large organizations are looking at how do you tap into resources around the world, again, using remote and virtual technology. There's a lot of activity in that space where a lower cost market or purely from a shortage of providers, we're talking to a company that's based out of the Philippines that does case management with RNs from the Philippines and if they can do remote-in can do those initial assessments at a fraction of the cost, real time, we can start that care and that final disposition in the first few hours of a hospital stay. I think there's probably going to be where we start to break down the cross borders stuff.

Matthew:

From a doc, it is logistically impossible to cross borders and practice medicine. It is, most of the time, they would make me go back and do my entire residency and that's true for almost every country in the world. So from a physician standpoint, you'd have to build those partnerships across the borders as well because that would be a challenge. I think it's going to be offshore first. I don't know that in the current climate that we would be talking about that.

Skelly:

And what I would say is we're constantly always looking at extending the benefit so we can meet the needs of the patient populations that we serve. The conversations are not easy to have and we have to be able to survive too. So we obviously can't have two patients and we're taking up a dollar amount that is exponential and suffers for the 99%. However, again to my point, we're absolutely having conversations to leverage technology, which we have to do. This is an opportunity just like the other that I described. We have to leverage technology and we have to be able to have conversations about patients crossing borders. Our patients don't want to live in one place and nor should they be limited to do so. If we can meet them at the 50 yard line, we should.

Matthew:

And I think the provider shortage will also drive that. There won't be enough docs. There aren't going to be enough nurses. At some point in time we're going to have to figure out how to take the collective

FTE's across the world and deploy them effectively. But that, that's another layer of complexity. We have a doc shortage pending in the United States pretty significantly.

Jim:

And NIC did a great job with putting together a great panel. But they missed political.

Skelly:

That might have been intentional. I don't know.

Jim:

Yeah, very intentional. I think that some health plans have done, I'd say a minimalist job. There's certain benefits on every health plan's portfolio that do cover them internationally but they're all for emergency based purposes. They're not for anything long term, which I think is what you're calling out. I think that there is one tangible thing that I feel at least in the news and in this country is that I think more people are agreeing that the current system in the States is broken. And so I do believe that there is a lot of investment looking into outcomes, results from other countries and how they're getting there less expensive than we are. Whether that there is more services or less services, I think is starting to be demystified. It's really that we're paying more here necessarily versus what we're paying elsewhere. And I think that some of our senior living partners in the audience have actually begun to go international. So I know there's lots of platforms that are homegrown in the States but now have properties in Mexico or in Canada or in the United Kingdom. So I sure hope that the answer is very soon.

Diane:

Other questions? Yeah.

Speaker 8:

How has your relationship with assisted living providers changed in the last few years and how do you envision that changing in the future? What role do you see assisted living, the senior living providers play in the post acute space?

Scott:

I would say from our lens, it hasn't changed a lot unfortunately. But going forward, like I was saying, that's one of the next frontiers that we frankly need to look at. When we talk about how do you drive community based programs, at Ascension, in most of our markets, we have a high volume of community based programs that we like to run. How do you integrate the established networks that we do have in the other Medicare levels of care but mix that downstream into senior housing as well. So I think there's a lot of opportunity for that connectivity piece that we've been talking about within a narrow group of assisted living providers by market. At least that's the framework that we're looking at for right now.

Skelly:

I would say it's time. It needs to change. We don't have the deep connection to the assisted living community that we do with SNF, that we do with home health, that we do with hospice and I think this week is a big week as for northern California Kaiser Permanente anyways because I'm really excited to connect with some operators that we can start growing those relationships with. I need to figure out how to get you guys reimbursed though. That's my job. I've got to figure that out. I don't know what that

looks like and I know it's different for different patients. I don't just have Kaiser Permanente patients that come into our hospitals. I've got all sorts of payers. We're held to those regulatory standards even though I know there's some talk out there that we only have Kaiser members in our hospitals. We don't. So I have to figure that out. But I have to because we don't have capacity in the SNFs. It's not there and we've got a population that's growing and I know that assisted living are doing incredible work and they are, from what I'm hearing, able to service a patient population that they haven't been able to in the past. So I'm excited to learn more, understand the capabilities, and partner. It hasn't happened but it's about to.

Matthew:

I would just add that from a leadership standpoint, your best front-line case managers know the assisted livings and use it as a tool in their toolbox for disposition. And sometimes we forget to go to the voice of the consumer. And your craftiest case managers know how to get people the support they need. And assisted living comes up often and it's a tool in their toolbox that's underappreciated.

Diane:

Do we have one over there?

Speaker 9:

You can hear me?

Diane:

Yeah.

Speaker 9:

I just had a question because I was curious about this but I wanted to hold this big dice.

Diane:

That's a nice box you have.

Speaker 9:

Yeah I know it's nice. Really you can throw it around.

Speaker 9:

So to Jim's point around keeping it simple and executing well, I have a question around the teamwork or everyone playing on the same team. I've worked with a number of health systems, specifically on the SNF side, and what's happened is you want everyone to play well as a team but sometimes your team, say the hospital, has a more capable team than perhaps, the SNF team, and as much as assisted living has changed the same thing has happened for skilled nursing, the level of acuity, particularly the complexity with mental health behaviors and so forth. And so what's happened is that we've had to even provide business advice at the SNF level to help them understand how to change some of their workflows, where to prioritize their time in a collaborative way.

Speaker 9:

And as much as we talk about assisted living, which is significant, we have to recognize that you have a certain net worth to even be able to afford assisted living and a lot of the drivers behind frequent flyers and hospital utilization, tend to be more the duals. Oftentimes, people with broken families, difficult situations, et cetera, which typically you don't have in assisted living context. So I'm curious, back to this theme around keeping it simple and executing well, are you finding yourself, even within your existing SNF networks, and by the way, what I've experienced is it's hard to exclude I guess the state of the SNFs today means that there aren't enough amazing providers, even if you have a narrow network. I've seen to elevate the performance even of those within your narrow network. So I'm curious, have any of you, particularly the health systems, have you gotten involved in a more collaborative way with your SNFs beyond just interpreting data and encouraging better performance?

Diane:

So we are negative time here so who would like to do the 30 second answer to that?

Scott:

I would say the 30 second answer to this is yes.

Diane:

That was good!

Scott:

It gets down to, really, low tech solutions. You need to be meeting regularly with the providers that the advisory piece of it is perfect, PDPM is a good example on workflow changes that just needed to happen. We did that exercise in a number of our markets. So you need to have those touch points. Discharge planners need to be closely connected with the providers on the SNF side.

Diane:

Good. Great. Well I'd like to thank everybody for coming today and our wonderful panel. We appreciate all the insight and hopefully we'll do more.