

## Join the Disruption Convergence of Healthcare Seniors Housing

Brian:

Good morning and welcome to the 2020 NIC Spring Conference. We're certainly excited to have you at the beautiful Marriott Marquis San Diego Marina. This is our first time at this venue. For over a year we've really been working with the hotel staff to plan out this conference to make sure you get the most out of it. Despite record attendance, this spacious venue will clearly allow us more room to grow over the coming years. So, we want to thank the Marriott Marquis for hosting us, and we're looking forward to many future events here as well.

Brian:

So, I want to take a moment to recognize another yearlong effort, that of our 2020 Spring Conference planning committee. This group of 20 volunteer leaders represents a cross-section of real estate and non-real estate-based seniors housing and Care players. They spent many hours identifying content important to investors, operators, healthcare leaders, pulling in speakers, and developing sessions that are relevant to your business.

Brian:

I'd like to specifically call out this year's chair, Jim Thompson of BOK Financial, and vice chairs, Colleen Blumenthal of Health Trust, and Joel Mendes of JLL for their dedication and service. I also want to acknowledge our host state executive, Craig Cornett, President/CEO of the California Association of Health Facilities.

Brian:

So, this year's conference theme is Investing in Seniors Housing and Healthcare Collaboration. The theme is based on the idea that partnerships and collaboration in seniors housing and care will continue to evolve. As the wants and needs of future generations of residents vary from those in seniors housing today, as changes in technology enable the delivery of healthcare services in nontraditional settings, and changes in payment models drive innovation and healthcare delivery pathways, seniors housing and care will continue to evolve. It has already begun to do so through new partnerships and collaboration with healthcare organizations.

Brian:

So, on any given day, seniors housing and Skilled Nursing is home to about three million or so older Americans. Many are already high utilizers of healthcare and many more are just one fall or emergency room visit from becoming high utilizers themselves. So, healthcare spend already makes up 18% of our GDP, and it continues to grow.

Brian:

The federal government seeking to control these costs is looking to harness the power of private sector innovation through tools like Medicare advantage. So, Medicare advantage enrollment grew by 9.4% year over year, up from 6.5% last year. It's about 34% penetration right now. If you look at the congressional budget office estimates, it will grow to 42% by 2028.

Brian:

So, states like Minnesota, Wisconsin, Oregon, and Florida already have Medicare Advantage penetration greater than 40%. So, these Medicare Advantage plans looking to bend the healthcare cost curve are

identifying segments of the population that use significant healthcare resources. One such segment is actually that population that cost three times more than the average Medicare beneficiary. That segment are those that require help with long-term services and support, which are defined by those that are in Skilled Nursing, those that have cognitive impairment or those that have or need help with two or more ADLs. So, this is overwhelmingly the population that is in seniors housing and Skilled Nursing today.

Brian:

Organizations responsible for controlling healthcare cost will increasingly take an interest in this sector. They're recognizing that seniors housing and Care also offers geographic density resulting in efficiency of care, and because each community typically houses about 100 or so high-cost individuals.

Brian:

Proactive, preemptive care can be delivered to them efficiently. This approach can reduce the number of trips residents take to physicians, other providers and the hospital, and it keeps residents healthy and happy.

Brian:

Add to the fact that only about 10% of early mortality is determined by clinical factors. 30% is determined by genetics. It's the remaining 60% driven by social determinants of health, an individual's behavior, what you eat, whether you exercise, as well as whether or not you're isolated or can socialize.

Brian:

These factors are highly influenced by seniors housing and care, which provides a purpose-built environment for aging, nutritious meals, socialization, and other benefits recognized to lead to a longer life.

Brian:

Healthcare is looking to save money while maintaining the same or better outcomes. Seniors Housing and Care is honed to geographically concentrated, higher cost beneficiaries with major social determinants of health benefits. Healthcare organizations offer services that enable a longer, healthier life for residents and they have resources to deploy.

Brian:

New partnerships and collaborations that breakdown some of those old silos will ultimately benefit not only the healthcare and senior care businesses involved, but they'll also benefit millions of America's elders.

Brian:

So, with that in mind, we've organized our program to include discussions on healthcare strategies and collaboration, as well as more traditional insights, of course, on real estate-based trends and investment data. Breakout sessions are divided into three tracks, so that you can select the topics most relevant for your strategic plan in the future.

Brian:

The real estate strategies track tracks those trends and valuations in seniors housing and Skilled Nursing, as well as capital flows in the space. So, this is where you're going to find the leading thought on property valuation and capital strategies with sessions like executing a payroll play, how labor strategies factor into investment decisions, as well as identifying value amidst turbulent market conditions and then, of course, the NIC blue book, current market conditions in the Senior Care industry.

Brian:

The next track is healthcare strategies in real estates, which examines the intersection of seniors housing and healthcare. These tracks such as project healthcare, designing an interactive care model that works, value-based strategies, partner, build, acquire are going to help capital providers, operators, and healthcare leaders explore how healthcare in seniors housing and care can improve bottom lines and lives through partnerships recognizing there's no one solution that fits all scenarios.

Brian:

So, the Senior Care collaboration track is going to dive into real world challenges and opportunities, as well as practical partnerships between seniors housing and care providers, and providers of care for older Americans.

Brian:

This is where you'll find sessions like what's the physician's role in the value equation and collaboration or competition, who owns the healthcare dollar? Overall, the program curated by the Spring Conference planning committee explores opportunities for seniors housing and Skilled Nursing operators and investors to build their own capabilities or collaborate with hospitals, health systems, and payers to create value for everyone involved, the community, the investors, the partners, and most importantly, the residents.

Brian:

The program also delivers the industry-leading content that many of you come to expect from NIC on factors influencing property value in the seniors housing and care space. So, I hope you'll take time to attend as many of these sessions as you can over the next couple of days.

Brian:

As you look over the session descriptions online or in the app, you'll see that our Spring Conference planning committee has really curated session topics and content that are highly relevant right now as you determine your strategies going forward.

Brian:

Now, before we move on to introductions of our opening general session speakers, I would like to recognize and thank the sponsor of this morning's opening general session keynote speakers, Bank of Montreal, represented by Imran Javaid and Ryan Stewart. So, we thank Bank of Montreal, of course, for your sponsorship. We literally could not do these types of events without sponsors like you. Thank you very much.

Brian:

So, this morning, we're fortunate to have a terrific panel of leaders to discuss the opportunities that arise as healthcare delivery changes. We're going to get a macro view of how healthcare delivery is changing and explore how that reality is driving positive change for a leading seniors housing operator.

Brian:

So, I'd like to welcome to the stage Moderator Bob Kramer, Founder and Strategic Adviser of NIC.

Bob Kramer:

Great. Thank you, Brian, and good morning, everyone. It's good to be here. It is an exciting agenda that we have today at this conference. I want to welcome you then specifically to join the disruption, conversions of healthcare and seniors housing. Yesterday, for those of you that were in the very well-attended session on Five Healthcare Trends You Need to Know, one of the key messages that came out of that was the disruption that's going on in healthcare payment and delivery. That disruption, when we say join the disruption, it's that disruption that really is why we're here in terms of this session and this focus with regard to our conference, and it's what's driving then this convergence of healthcare and seniors housing.

Bob Kramer:

Let me say that I think it's important to acknowledge upfront: this is uncomfortable territory and an uncomfortable topic for many of you. We are an industry in terms of private pay seniors housing that was defined in terms of it was non-institutional, it was residential. With that, we didn't provide healthcare. It was hospitality. It was supportive services, assistance with ADL needs, but it was not healthcare. That was part of the DNA almost of the identity of the sector.

Bob Kramer:

What we're talking about here this morning and throughout this conference is the reality of how things are changing such that we have an enormous opportunity. Whereas before we were not even part of the discussion about delivering health because the focus was only on healthcare in the medical sense. Now, we very much have the opportunity to be part of the discussion, but I, those of you that know me know I'm a really positive glass is half-full type of person.

Bob Kramer:

There's another side to that, and that is the trends we're talking about are trends that are going to transform the care of frail elders with multiple chronic conditions and ADL needs. So, either we will seize this opportunity and take advantage of this or others from outside of our space will disrupt us right out of our core business.

Bob Kramer:

So, there's a driver here. There's a huge opportunity. I'm going to look at it from the point of view of the opportunity, but I'd be remiss if I didn't say as an operator of assisted living, memory care, independent living, CCRCs, and skilled nursing or as an investor, this is a topic you need to be paying attention to because in three to five years, it's going to turn upside down how we think about the care for what are called older adults with complex needs that I would translate in terms of many chronic conditions layered over with significant ADL needs.

Bob Kramer:

So, what we're going to talk about throughout the day and starting off this morning is how do we take advantage of this opportunity we now have. We're not going to say there's any one way to do it, but we are saying you will either engage on this opportunity or you will find yourself no longer the preferred setting for caring for frail adults with complex care needs. So, that's my usual mild statement about the situation that we're in, but hopefully enough to get your attention.

Bob Kramer:

So, okay. Oops. What's the key driver of this disruption? You hear a lot about the move to value-based care and so forth, but it's important to understand as was pointed out in the Five Healthcare Trends session yesterday that you need to know. The overall driver of this is the rising cost of healthcare or put another way, it's the unsustainability of spending on healthcare and recognizing that 5% of the population accounts for 50% of that total spend, and that's also true in Medicare that 5% accounts for 50% to 60% of the total spend.

Bob Kramer:

Guess what? Many of them are our residents. If we ignore that reality, we're missing out again on a huge opportunity. So, unsustainable spending means that at the federal level, there's great concern about the rise and the growth of Medicare, as well as the federal share of Medicaid. At the state level, that means that governors are preoccupied with looking at what's the trajectory of Medicaid cost, and how that's going to progressively eat up now half for many, progressively two-thirds, three-quarters of their state budget in a way that's totally unsustainable, crowding out other priorities.

Bob Kramer:

So, the point is that when you hear a phrase like managed care and Medicare Advantage plans, which is a form of managed care and having private insurance take capitated risk, in this case, for seniors, you may think, "Oh managed care, I remember when we dabbled in that as a country," and I remember because I was a state legislator in the forefront of healthcare issues in Maryland in the 1980s, when we were into managed care and utilization review boards, and so on and so forth.

Bob Kramer:

Guess what happened then? There was a consumer reaction against it, strong. The wave that was going to be managed care died down to a trickle. It's going to be different this time. Why? Because now, we don't have the luxury of time. Now, policymakers, again, why is it that in many ways the Trump administration and led particularly in this case by Seema Verma at CMS has doubled down on many of the policies in the Obama administration, namely, to create greater transparency and free the data, and secondly, to force risk, particularly downside risk amongst healthcare providers, whether their health systems or doctors, and that is not going to change.

Bob Kramer:

So, where a lot of experiments and you'll hear about a number of experiments today and tomorrow, but don't think that because some of these experiments will fail and they will that we're going to go back to business as usual. Because of the urgency of this cost and unsustainable growth, the reality is that folks will go back to be even more prescriptive in terms of trying to force solutions that are going to get control particularly of cost to the highest cost individuals in our healthcare system, and those happen to be most of our residents.

Bob Kramer:

So, that's why we're talking. In one sense, that's why we're talking about healthcare disruption because that's where it's coming from. There's a lot of important talk about value and quality, but ultimately, it's cost and unsustainable expenditures that are driving it.

Bob Kramer:

So, as we look to the future, and this is really we're looking now, it's now and especially the next three to five years, four key things I want to just, as concepts defining this. Again, this is not defining something out there that has nothing to do with what we do everyday. This is something that's going to change the nature of how we meet the health needs of our frailest residents and of our most expensive healthcare consumers.

Bob Kramer:

So, first, the drive to home. You can't understand what's going on there today, what's going on in healthcare today without understanding the drive to home. What this means is it's consumer-centric. It's if you want person-centered, but it's the desire to more and more have things that are convenient to me, and most of all, that means in my home.

Bob Kramer:

Way I would put it is this drive to home in terms of healthcare is what consumers increasingly desire what technology is helping to make possible and what payers and policymakers are increasingly willing to push in both policy and payment guidelines. Why? Because they think it's going to save them significant healthcare dollars.

Bob Kramer:

Secondly, beyond home is the move. One is drive to home. The second is the move from volume to value or put another way, value for whom. Previously, our healthcare system was really around value for healthcare providers, and it was all about volume. It was all about how much fee for service revenue you could collect by how many procedures or days in hospital that you had. That's changing now.

Bob Kramer:

Why? Because now, the driver is the value, first of all, to whoever is paying for that healthcare dollar, either a government entity or now through capitated risk and managed care plans in both Medicare and Medicaid increasingly its value to that insurance company that's taking the capitated risk for the total spend in a year for that individual on their healthcare.

Bob Kramer:

So, this is a move from a volume-based silo-driven model, where you want to maximize what happens in your setting. To be blunt, you don't have a lot of concern about what happens in other settings because all your revenue model is based on maximizing volume. Now, it's about value. When it's about value, you have to care about what happens when a person leaves your setting and also you have to care about what's happening to them before they get to your setting.

Bob Kramer:

What does that mean? What that means is it drives the third concept, which is partnerships. Very few people are going to have expertise or are going to own all those different if you want pre and post settings. This means that the role of partnerships, the role of managing and coordinating care in terms of focus on the total outcome of the health of the individual not maximizing the days in my setting is it now reorients towards the importance of partnerships.

Bob Kramer:

If partnerships and vertical integration both up and down, if you want, in terms of home care, home healthcare, palliative care, and in terms of physician provider groups taking risks, and health insurers also having health service platforms, and health systems.

Bob Kramer:

Final piece would be risk. Again, as I mentioned before, government and I don't think this is going to change because of a change of administrations. We've already had one change of administration. We didn't see a change is a push towards more and more forcing risk, forcing risk ultimately on both the individual who is now taking the risk for the healthcare dollar spend and the individual that's going to be providing the care or the services.

Bob Kramer:

So, you're going to hear a lot about risk. One of the important points is we at NIC, and this program is not saying, "Gee, every single Senior Housing and Care operators got to get into taking risk." What you decide on what's your tolerance for risk is your decision, and there are a lot of factors, which hopefully can play into that.

Bob Kramer:

Ultimately, you've got to understand that somebody is going to be at risk for the total healthcare spend of the residents in your building. That person is going to have a vested interest in what is happening in your building, and it's either going to be good and they're going to like it, and they're going to incentivize their members to be in your building or it's going to be bad, and they're going to do everything they can to keep their members out of your buildings in the future as long as you're serving this frail elderly population.

Bob Kramer:

So, in some healthcare payment and delivery disruption, massive shift in healthcare delivery and payment model, moving from a siloed, fee-based volume, fee for service system to integrated, outcomes-driven, value-based model, driven by cost concerns, major impact so far has been on government--reimbursed care, not as much on the commercial carrier market, changing role of the acute care hospital. This is key. Accountability for what happens after and before the hospital.

Bob Kramer:

So, this leads to the focus on post-acute care, what happens after. The focus is on pre-acute, what happens before. I've coined a phrase, which I think is more descriptive and that is we are moving to a health system that is focused on, that has a peri-acute focus. What I mean by peri-acute is from the Latin surround, and it's the idea that in the future, a system that's focused on prevention and wellness is incentivizing everyone in the system to do everything they can to keep folks out of the acute care hospital, and out of that institutional type setting and to keep them out of the emergency department.

Bob Kramer:

So, peri-acute, putting a moat around the acute care institution has major implications for the future of healthcare systems, obviously, but it is the reality of where we're going when we move from a curative intervention model to a model that focuses prevention and wellness and chronic disease management.

Bob Kramer:

So, with that, as we think about things that way, this has enormous implications for the Senior Housing and Care setting. It all focuses around the change in the understanding of what constitutes health. Up until recently, health has been equivalent to healthcare, to the quality and the amount of medical care you receive and your health was seen totally as a factor of that. Yes, some your genes, in other words, your family history, but now as you heard earlier from Brian, that as you see from this slide, that 10% now that's due to clinical care is 10%. 30% is genomics, family history. That's only 40%. 60% is behavior and environment, where you live and your individual behaviors.

Bob Kramer:

What that has meant is that a number of years ago at this very spring conference, we had a discussion about post-acute care in relationship to acute care. Arnie Whitman made the point at the time that post-acute care has always been at the kids' table when it has come to healthcare delivery. I followed up with a comment and said, "seniors housing has never even been at the table. We've never been seen as part of healthcare delivery and healthcare outcomes."

Bob Kramer:

Now, with a switch to seeing that 60% of health, of what drives health has to do with setting, where you live and environment, and behavior, diet, exercise, socialization and social engagement, and prevention, and wellness, we've gone from not being part of the discussion, from being irrelevant ultimately to healthcare delivery to be a key setting that happens to house a large number of the most expensive individuals in our healthcare system. The opportunity for us is huge, but we have to take advantage of it because others see this opportunity, too.

Bob Kramer:

The more we say no healthcare happens in our buildings, you're on your own to figure that out in essence. We'll just help you with activities of daily living. We are inviting others. We're inviting Google. We're inviting Amazon. We're inviting Best Buy Health with a focus on passive remote patient monitoring. We're inviting CVS Aetna. We're inviting Walmart to literally steal much of our business and much of our business model.

Bob Kramer:

So, where does this take us? In the future, healthcare will go to where seniors, especially frail seniors live rather than forcing these seniors to go to the hospital or a doctor's office to receive their healthcare. Boomer consumers will demand it. Technology will enable it, and payers, managed care will pay for it because they believe it will produce meaningful, meaningful healthcare dollar savings.

Bob Kramer:

Let's put this another way. About four years ago, I interviewed a United Health executive. At that time, we were talking about the seniors housing and care setting. He said to me, "I would give anything to have my eyes on our plan members 24/7."

Bob Kramer:

My response to him then was, "You need to meet some of the folks that we work with every day because they have their eyes on your plan members 24/7."

Bob Kramer:

We have enormous embedded value as Anton Winston likes to say in our setting. We are in their rooms on a daily basis. We are controlling their diet. We're able to drive exercise, and socialization, and social engagement, and life enrichment. All things we know and what's now called social determinants health, which as to do with housing, which has to do with food, which has to do with social engagement and sense of purpose. All of those social determinants now make us having a front and center opportunity. Whereas before, we were irrelevant.

Bob Kramer:

Put another way, as I said, we monitor 24/7, 365 our residents. There is enormous value in that to the managed care players out there. We need to learn how to take advantage of that. There's also enormous value in the data we have the opportunity to collect. We collect some of it now, but we could be collecting much more, much more data that would enable us in a proactive preventive way to ensure whether we're doing it or those that we're partnered with, that we're managing those chronic conditions to reduce hospitalization rates, to reduce use of the ED, and to enable people to live longer, healthier in our setting.

Bob Kramer:

What does that mean? That means the very issues that may have caused some of you to say, "This isn't relevant to me. I'm so focused on occupancy. I'm so focused on labor cost. I'm so focused on just the day-to-day challenges of operating my building that this stuff, it's too out there," but the reality is as you'll hear from different folks throughout this conference, those that are doing it now are seeing longer lengths of stay, are seeing happier, healthier residents because let's face it. People don't just want lifespan, they want health span, and we can be key to driving health span for this frail population.

Bob Kramer:

So, again, this Venn diagram, some of you have seen this before, but when we coordinate and, even better, integrate the care silos, enhanced housing services, providing transportation, providing meals, so forth, support for functional needs, ADL, classic ADL needs, and healthcare, medical services to really proactively manage those chronic conditions, to anticipate in ways that can prevent to the greatest extent possible, falls or UTI infections that require a hospitalization, where that fall or that UTI infection requiring a hospitalization starts at times almost an inevitable downward slide for that individual.

Bob Kramer:

You know what? Lowers your length of stay, puts more pressure on your occupancy rate. Because of the fact that you're not providing this additional value also enables you to not drive rates in the way you'd like to be able to. So, this is very relevant.

Bob Kramer:

Now, my final slide is just to make the point that Brian alluded to in his comments. In the discussions, unfortunately, my third panelist, Kirk Allen at Humana at Home, was not able to be here because on Tuesday, Humana announced a travel ban for its team. In talking with him beforehand, he said to me, and I don't know if he had seen this slide that came from ATI or not, but he said to me, "Bob, our most expensive plan members are folks not with multiple chronic conditions, but as soon as you layer mobility limitations on top of those chronic conditions, our costs go through the roof."

Bob Kramer:

He said, "Secondly, those are the most expensive people for us also because to bring the care they need, the individualized care into their home, their private home in terms of their apartment or their single family home or because they have mobility needs to then get them to a care center type of center is enormously expensive for us."

Bob Kramer:

He said, "I'm intrigued by the setting efficiencies that, A, you're almost pre-selecting in your residents exactly our target group that's most expensive. Two, in doing that, you have folks a hundred at a time or more. That's an enormous opportunity to deal with a population that right now is our most expensive plan member."

Bob Kramer:

So, you look at this here again. Chronic conditions alone are not what drive very high Medicare costs. What drive them is the chronic conditions combined with the functional impairments, whether due to cognitive ability limitations, but once you do that, as you see, the numbers more than double in terms of the cost of that individual.

Bob Kramer:

So, this is a quick tour that I hope has begun for those of you that wondered, "Why is NIC talking about this?" We're about seniors housing. We're a hospitality model. We do a great job with what we do. We provide badly needed support for people in mobility issues, cognitive issues that have functional limitations.

Bob Kramer:

The reason we're talking about this is that folks now have a vested interest in caring about the healthcare outcomes and dollar spend of your residents. You have an opportunity to play a key role in that. If you don't, someone else will take your place to do that because that has to happen, and whether you're a state governor and a legislature or the federal body, you are scared to death by what's happening in unsustainable cost in terms of healthcare spending, especially now in the entitlement programs.

Bob Kramer:

So, with that, I'd like to invite my fellow panelists to come to the stage, David Nash. Dr. Nash is the Founding Dean Emeritus of the Jefferson College of Population Health, and has been a longtime leader, one of the leaders in the population health movement in this country, has published widely on this, and

has really been a staunch advocate, puts on one of the major conferences in population health each year, the Population Health Colloquium held in Philadelphia.

Bob Kramer:

Dan Lindh is a longtime leader in aging services as the CEO and President of Presbyterian Homes and Services based in the Twin Cities, Minnesota area, and an innovator, who from a mission-driven point of view as taken very seriously how do we best meet the needs of our residents, including those who cannot afford the average private pay senior living setting.

Bob Kramer:

So, I'm delighted to be joined by these gentlemen. I'm going to take a seat to join them. Welcome.

David Nash:

Thanks. Great to be here.

Bob Kramer:

Dan, welcome to you. David, welcome to you. So, I've tried to frame the situation. David, you're coming, in one sense, you're an outsider, though not totally. You've been very much at the center of what's happening in changes in healthcare and healthcare reform, very much driving the understanding of population health, but you're just in the last couple of years gotten exposed to NIC, joined our board as one of what we call outside directors, meaning you're not involved day-to-day in the operations or financing of seniors housing and Care.

David Nash:

I am a year away from Medicare, however.

Bob Kramer:

All right. Okay. So, I want to ask you, first of all, what do you see from your point of view, what's the value proposition in terms of this convergence of housing and healthcare? What do we mean by convergence? What's the value proposition? Specifically, what's the opportunity and the challenge for seniors housing and care providers?

David Nash:

Sure. In 10 seconds or less. Great. Well, first of all, thanks again for inviting me. Great to be up here. Wonderful to meet you yesterday. For the folks who were at the executive summit, thanks for your participation in that. It's been a really great experience for me to be on the NIC board for the last two years. So, wow!

David Nash:

So, I thought you did a great job, Bob, laying out the four things, the home, value, partnerships, risk. So, for convergence, here's my sense of things and the disruption. I mean, two words, disruption and innovation, I think, if people hear those words one more time, they're going to tear their hair out.

David Nash:

So, here's where I think we're headed. You almost said it. So, look. Defining value is hard to do. It depends on your perspective, right? Here's where I think we're headed. You said it. Spending is unsustainable. What are the numbers? Let's make it so people can really appreciate.

David Nash:

So, our total industry, healthcare industry, we're 20% of the GDP. It's roughly \$3 trillion. Every day, Medicare spends roughly a billion dollars part A and B, a billion dollars a day. Our industry taken as a whole if we were to secede from the union, healthcare would be the sixth or seventh largest GDP worldwide compared to other countries.

David Nash:

So, we've been hearing about unsustainable for a longtime. Guys like you and me have been talking about this, but I really do think now we're at that inflection point. Every governor, as you alluded to, this is her biggest problem. So, what's a potential solution. So, one potential solution promulgated both by the former administration and the current is let's go upstream, shut the faucet instead of mopping up the floor.

David Nash:

What does that mean? It means, "Well, let's find a way to achieve value instead of just billing for volume, for everything we do." So, the tool to get to value has a lot of names. Here's the punchline. We could call it bundled payment. We could call it global capitation. People hate that word. We could call it a global fee. I prefer bundled payment because it connects, Dan, you and me.

David Nash:

So, I think the senior industry represented here, the folks who come to a meeting like NIC, you laid it out. You're at the tipping point of an unbelievable opportunity because these patients live with you. You got eyes on them the whole time. If you could become part of the hospital provider solution to reduce readmission, tackle these social determinants, then you and I could get connected in a new way, in a new world order to really achieve value.

David Nash:

So, summary. When I see the disruption and the convergence, what that means in my head is in a bundled payment world from a hospital perspective, maybe you could help me, the hospital, reduce my readmission burden for heart failure because Jane lives with you, and you control her diet, and you control her exercise. I sure as heck don't do that.

David Nash:

So, if we could find a way to work together in this spectrum of care, you've got a piece of the action, I have a piece of the action, and we could both benefit. Oh, and by the way, Mrs. Jones will do better, right? I mean, that's important. Then I think we have convergence, disruption, and opportunity all shining at us at the same time.

David Nash:

So, here's the punchline. To me, it's all about let's connect the dots. Your industry, this industry that's represented by these amazing people here, the acute care industry, let's find some new ways to work together. We'll get into some of the details, but you did a great job, home, value, partnership and risk.

David Nash:

Let me conclude at least this question. This is going to be a test in part of this crowd's appetite for risk. That's really what we're talking about because the road to risk is the road to redemption. Let's do that one more time. The road to risk is the road to redemption to help fix at least aspects of the cost problem.

Bob Kramer:

Well, let me pivot then, Dan, to you. I'm an operator here in the audience, and I'm thinking this sounds great. I should help out the state governments for their budget problems. I should help out the feds. I should do the good thing for my residents, but I'm going to lose my shirt because it's not sustainable financially. I ultimately got to deliver an NOI for my investors and for my ability to stay in business. So, as an operator, what's the value proposition for operators that's created? We're saying there's an opportunity as a result of this disruption. Is there an opportunity to lose your shirt or is there an opportunity to not only make a difference that is better for your residents?

Bob Kramer:

Someone commenting on social media on some of the sessions yesterday commented that the combining of housing and healthcare under one roof is demonstrating that that collaboration is producing better results for the residents, as well as better results for the operators, and better overall healthcare dollar savings. I'm an operator. I'm thinking, "Yeah, but am I going to do the right thing and I'm going to suffer financially because others are going to take all those dollars." So, could you speak to that?

Dan Lindh:

Yeah. Thank you. I'm happy to. We, as a provider like a lot of other providers here in the room, are trying to anticipate and take good care of our residents and think about the future in different ways. As an organization, we serve about 27,000 people a year, and about half of those are under our roofs, and we have a continuum of independent living and probably about 6,000 doors there, and another 2,500 or something in assisted living, and another 1,500 in care center with assets in post-acute and transitional care and a layering on, a vertical integration of a series of home and community-based services.

Dan Lindh:

So, for us, the journey began around outcomes we were looking for, and why we're involved with it are both missional, quality, economic, and brand distinction. I have no magic answers, but I can tell a little bit of our story, and I'll give you some real numbers, and our approach.

Dan Lindh:

Our journey really started, we do a lot of work with our customers in understanding their journey, measuring their satisfaction, working net promoter scores, doing the same for employees, trying to bring those up together, which is according to Gallup, where you get your biggest boost in terms of brand and effectiveness and census outcomes and so on.

Dan Lindh:

As we were doing a lot of work on that, we started to notice a couple of things. One is that when residents and customers were very engaged, they just did better. Didn't seem to matter what else was going on in their sphere. If they were living to purpose, a term we use, if they had a lot of friends, they would tend to take better care of themselves. They would tend to exercise more, and their social determinants were stronger.

Dan Lindh:

We noticed others that didn't seem to have that corollary were doing more poorly. So, we first took an initiative of what can we do to help them. Then, additionally, when we looked at the information, the feedback, what we discovered is that our customers, particularly in assisted living and memory care, had dissatisfaction with how primary care, in particular, and how the healthcare system as was being defined was coming at them and their families.

Dan Lindh:

As we studied that, we've felt like we had an opportunity to do something about that. So, in some remissional quality economic and brand distinction, our average customer under our roof operations comes to us at about 84 years of age. They stay with us for seven and a half years. They use four value streams, typically, one of them being either assisted living or memory care, but on average, four. They spend \$350,000 with us from their start to their finish. Our age ranges go from their late 50s up to about we have 98/100 with the oldest one today being 108.

Dan Lindh:

What we've found is that in heavier care needs, what was dissatisfying to people is that physician visits, I'll characterize as coming to them like wellness visits like they would be at a clinic, but the reality is they're dealing with multiple chronic conditions, and what they really needed was time, and they needed engagement with the rest of the system.

Dan Lindh:

So, to summarize here. Let's see here if I can-

Bob Kramer:

Just keep going if you want to go through the next couple of slides to get to those.

Dan Lindh:

Okay. These are ones Bob was going to cover with you. So, imagine him being, okay, right there. So, again, the Kaiser triangle. 10% traditional health, 40%, and then genetics to 30%. 20% are where you call home. The 20%, you've seen this before, where you call home. We felt like we were doing that pretty well. We felt like we had an opportunity impact, the upstream behaviors in a profound way and we're also tangentially working on some of the genetics, and we're actually piloting some genetic testing and giving people counsel about activities and upstream behaviors they can take, as well as diet and medications, and so on, which is interesting.

Dan Lindh:

So, our healthcare, if we set up a healthcare plan and reform committee, we got people up from outside our typical field to join our board. They hired consultants and Tomlinson helped us for a couple of years and others as well. Then we did a little bit of a study to see what we were spending on a ruff. What we discovered is this typical, maybe not for-profit organization, our top line revenue is about 500 million a year, which doesn't really matter, but was stunning to us, at least to me, as when we really got granular about what our customers that were spending that 500 million with us were spending in the healthcare system. We found out that they're spending \$300 million a year, and that we were not really being part of that particular number. We were just trying to get physicians in, trying to get managed care.

Dan Lindh:

We had press from some of the insurance companies that wanted to enroll more of our people, and we'd say to them, "Well, why is that?" We had one insurer say as boldly as this, "Because what we measure is under your roofs. When we insure people, our margins are the highest."

Dan Lindh:

I thought, "Well, that's an interesting and pretty direct statement." I said, "Well, if that's the case, then maybe we have an opportunity to do something ourselves."

Dan Lindh:

So, as you can see on this slide, we're coming at this from two ways. On the right-hand side is life enrichment, wellness, diet, all those factors that contribute to upstream behaviors. I feel like if we would do that well all on its own, we would succeed as an organization. This is one of your questions, Bob, is, do we need to be in the space? I don't think we need to be in the space. I view it more as an opportunity.

Dan Lindh:

On the left-hand side is now primary care and care navigation. So, what we did as an organization is said, "Well, where are we going to play in the space?" We were already doing fee for service. We were already doing bundles in Medicare and other. We were both taking measured risk from some of the plans. So, as we talk it through with the board, we decided, "Okay. What we're going to do is we're going to go to the very far right under full capitation."

Dan Lindh:

We're going to become our own plan. We spent probably about \$2 getting to that point. We actually made a lot of headway, but we got stuck at a point, started even to build some of our own infrastructure on the admin. Where we got stuck was is access to the network because if you do this on your own, you got to create a network. So, now, you got people like us all talking to the plans and to the acute care systems and saying, "Well, what's a hospital day cost for us in our system? What does a specialist cost?"

Dan Lindh:

What happens is it goes like this. Well, our rates go from 1,700 a day to 3,000 a day, and for the volume you're bringing us, we can give you a special deal at 2,999.99. You put a lot of those in your mix of your underwriting and your plan and it doesn't work.

Dan Lindh:

So, we fell back to what you see highlighted there is near capitation and we went out to contract with plans, and we asked for and received different levels of risk capitation, our sweet spot, and what we had with several of them, is that we paid the plans 10% roughly. They do the marketing, the administration. They maintain the TPA work in the pool. So, I'll speak to that a little bit more in a minute, and then 90% of the dollars flow through to us.

Dan Lindh:

We started on our own doing that, and we had pretty good success with that, but we hit the wall when we had ... Of that 300 million, we captured about 10 million in our plan, and we realized that we were not going to have the volume or the ability to get this on our own, at least in a reasonable period of time.

Dan Lindh:

So, back to your second term, which is huge here, is we felt like we needed a partner. Then we thought that through. We decided to partner in two ways. One is with the plans, and second is with some of the big healthcare systems, healthcare systems being the hospitals. We ended up with Allina. They have, I don't know, I don't know how many hospitals they have. They're about a \$5 billion company. They have about 1,000 physicians on their payroll and other connections. They have a specialist.

Dan Lindh:

So, we were able to find and purchase a 50% interest in a mobile primary care clinic with Allina. At the time we purchased our 50% interest, that clinic was a niche clinic that Allina would refer. Now, they're dealing with big panels of people in their clinics. What would happen is that the complexity of the older adults that they were serving would get to a certain level, they would triage them out and into Genevive. That was the genesis of it.

Dan Lindh:

So, by us buying a 50% interest in that clinic and expanding it, we brought that basically in-house. Today, Genevive has, when we purchased our 50% share, they had 35 physicians. We added our fledgling 12, Allina added a few more. We got up to 52. We're just in the process of adding a few more. We're going to have ... Right now, as of this day, we have 92 physicians and MDs in the plan. We have those physicians co-located in all of our communities. We've established what we'd like to call a geriatric center of excellence.

Dan Lindh:

Why this is important is that when our customers move from multiple value streams, even the big ACOs when they plant docs says, "Well, here's a panel of docs that deals with assisted living," or we do care center or we'll put stuff in for IL only, but you got to see the clinic. Our residents don't live like that. When we ask them the questions and saw disruption that they were having in their lives, what they ask us is, "Is there some way you can keep the primary care practice in flow with how we're experiencing life because we don't like all these changes?" Whenever we have changes, there's higher risk that comes with it as well.

Dan Lindh:

So, the model we have now is in a different way is we have CMS paying money to a Medicare advantage plan. That Medicare advantage plan, I should say Medica on there, Blue Cross Blue Shield and UCare. Those are the three big plans we have. At the bottom is a delegated plan. That's the plan that gets to 90%. In our case, this is one example is Medica and Genevive. This is the way it's branded to our customers, Medicare advantage plan from two trusted partners. When it's represented in the community, it also have Allina and Presbyterian Homes logo on it as well.

Dan Lindh:

Today, we have about 7,500 customers in that plan. It's growing nicely. We have a D-SNP plan, which today of that we have-

Bob Kramer:

D-SNP meaning a dual special needs plan for special people who are both Medicaid and Medicare eligible.

Dan Lindh:

Yes. Thank you, dual, and an I-SNP, institutional special needs plan. So, you have a C-SNP would be your general Medicare advantage plan. Duals are for people who would be qualified for a nursing home care or high levels of care. I-SNP would do the dual. It would also bring in Medicaid. The I-SNP would bring in only the Medicare side.

Bob Kramer:

So, in essence, you have in your partnership a plan that's doing all the back office stuff of being an insurance plan. Then you have, if you want a medical services provider organization in Genevive. Then you have yourself and other providers, other seniors housing providers who have all teamed together.

Dan Lindh:

That's correct. So, we own 50% of Genevive today, and we are doing synthetic build of volume in our communities. By the end of next year, we will have our plans in 150 provider communities and having scale on micro markets matters here. We're going to probably come back to that. It allowed us to build that kind of scale. So, we will have it, and we aspire to get to about 10,000 capitated lives.

Dan Lindh:

The slide here, you should have on your iPad, too, is just illustrative of how the numbers work. So, the practical numbers are if you're a D-SNP, it's both the left-hand side, the Medicare only, and the Medicaid. So, there we get \$3,500 per member per month on average of which the plans often take about the 350. If it's I-SNP, it's on the left-hand side only, \$2,000 a month. The customers that have signed up for this are averaging 87.5 about eight years of age. They have on average six chronic conditions. When they come to us, even in our own communities with the way medicine is practiced, they have 15 on average prescriptions. We were able to bring that down to nine in the first two months, which has been a huge benefit to them and to the families as well.

Dan Lindh:

How that's happening is that the doctors there are talking with our staff and getting feedback on the living environment. They're meeting the families. They're part of the care plans. So, they're getting

multiple additional inputs. It's the relationships that seem to drive it just as much as the data. So, that's our experience right now.

David Nash:

Wow!

Bob Kramer:

Dan, let me just ask you. Again, I'm sitting here in the audience, I'm thinking, "Wow! That's impressive. You put all that together." Again, I'm trying to run my community everyday. I'm concerned about occupancy. I've got enormous labor pressures finding, affording the quality staff that I know I need. If I'm sitting here and I'm thinking, "All right. Do I stay on the sidelines for this and take a pass for now? Do I prepare for it but very cautiously or do I jump right in?"

Bob Kramer:

So, help particularly operators in the audience because I know you went through a process, but what kind of evaluation do you need to do as a Senior Housing and Care provider? What kind of infrastructure considerations do you need to consider? It's not as simple as a checklist, but what are the things if I'm at all convinced at least to take a look at this and think about it? What are the things I need to be taking into mind? Just give us briefly what the considerations that you all had. I mean, this is really ambitious what you're doing, but it took you a while to evolve to this point.

Dan Lindh:

It did. It did. Well, first of all, we're a provider like everybody else in the room, and we stumbled, and we can prove. We've got bruised up toes from taking the wrong steps. This is maybe one at the end. We're trying to be thoughtful about it and take some steps that we think even if we end up x-ing the plan, we'll still do our infrastructure. That's a key point because we all have bricks and mortar. We think about 40-year lives.

Dan Lindh:

One of our great board members said, "Your strategic plan thinking in terms of where you'd take risk and how you do it should be first cognizant of that it needs to be as long as the buildings and the commitments you've made to people including lenders, capital markets and so on."

Dan Lindh:

So, the first thing we did is try to measure the risk and say, "Can we take this risk and still preserve great performance, maybe even improve performance in the core assets." The conclusion we got to is, "Yes, if we put boundaries around it." You can see in this blue sheet as you get to the bottom, even though we're taking full risk, there's some reinsurance recovery numbers in there so we're not crazy about it until we get a better run rate and higher volume.

Dan Lindh:

So, it's a little bit measured. The next thing we did, though, is we hired great consultants again Anne Tomlinson was one, but we recruited board members, too, who had experience in this space. We were curious about how from the acute care side and the managed care side how this might work. So, we had that kind of advice at the table advising our board, and then we actually also went out and recruited a

couple of staff that were very atypical to at least what I've been experiencing in my career, which now goes a little more in 40 years here in terms of what you'd normally hire in capacity.

Dan Lindh:

We hired people who would run insurance plans, a couple of them and who were used to taking risk. We taught them our field, and had them interact with our leadership team and our board in an ongoing basis. We had a committee dedicated to it for a couple of years. Early in the game, our conclusion was watchful waiting was the best thing to do to get an understanding of what the plans were up to, what they were going to do, what was shifting in the market, where the money is flowing, get better detail in our own metrics and data about what we were spending and why, and what the dissatisfiers were.

Dan Lindh:

Then we actually launched post-acute network where we built transitional care with a lot of care pathways that were later used in these insurance plans. We developed them in this case with Allina again in their clinics, in their lien people, in their process improvement people connecting to what we were doing, to what they were doing in their hospitals coming alongside on anybody that was one of our residents was admitted or inserted to their hospitals, too. So, we started to develop some capabilities without taking this kind of risk. That was an interim step.

Dan Lindh:

Then about probably two years ago, we said, "Okay. We think we're ready for the next step. We're willing to put a few million dollars at risk, and if we burn it up, we think we can still survive. Then we're going to take a risk. The run rate of this, by the way, with our current enrollment is about 140 million a year. You can see at the bottom there by watching the pools, each one of those pools on there, which I'm not going to go through, but it gives you an idea of where the spends are and the goal here is to spend more under our roof with more physician visits.

Dan Lindh:

With the people that are signed up so far are now able to give each one 10 visits a year with the primary care doc of a half an hour each. The other two times a year those primary care docs are meeting with our team. Before, we had erased the plan. We didn't have that capability. Second, you try to drive hospitalization cares down and manage pharmaceuticals. So, a great example that happened just last week, which I think is we're seeing these kinds of events pop up. We had an assisted living community in the south part of the Twin Cities, 6:30 in the evening, of course. Most of our staff are home. Event occurs.

Dan Lindh:

The nurse on duty says, "I think we got to have an ER visit," but in our new role, they call it triage. Our Genevive doctors are on-call somewhere along the line 24/7. They talk to think it through. Now, what we've found is a lot of times why ER visits happen is because nurses are scared, basically, of the regulatory ramifications to their license of making the wrong decision.

Dan Lindh:

So, if they can talk it through with someone and someone else helps them with that decision, then they can boldly take some steps. So, in that case, we moved that resident, brought in a physician visit, changed

the pharmacy on the fly, got the drugs there within an hour, moved the person to a transitional care just down the hall. Two days later, they were able to go back to their assisted living apartment.

Dan Lindh:

I don't know how much money we saved in that transaction, but what I do know is the customer was very happy. The family was thrilled. January in Minnesota was part of it, I think. The outcomes that other ... The buzz that went around that to the brand picked up, too. So, that would be an example of a great win.

David Nash:

So, Bob, that's the value answer right there, right? I mean, that's the triple lane, too. So, improve the health of the population, reduce per capita cost, and improve the experience for the patient. So, you did all of that. Obviously, it took some energy and planning, but listening to this, it blows my mind what they were able to create.

Bob Kramer:

Well, let me again play a little bit of a devil's advocate. You have significant size and scale in your market, as well as a financial strength that enable you to take some risk, as you said, without it undermining the whole operation, jeopardizing it.

David Nash:

Yup, and a great care partner in Allina.

Dan Lindh:

Allina is huge, by the way, because access to physicians, how they're trained, there are things that we don't do in our portfolio. So, that's an add.

Bob Kramer:

Sure. So, let me summarize just a few things for operators thinking about entering. One is you've got to know your local market. Local market doesn't mean just referral sources. Local market means who has the healthcare dollar risk in your market either as a Medicare advantage plan or an ACO, a downside risk. Who has the healthcare dollar risk in your market?

Bob Kramer:

Secondly, you need to know your own organization. What are your strengths? Who are the potential partners in the market? There's a lot of prospecting to be done. Also, what is your tolerance for risk? There are lots of ways to come at this, your total risk that as Dan's model, but there are also ways to literally co-locate, as the examples used yesterday like a Starbucks and a Target or opportunities to have partnerships where you're not taking the risk, but you're partnering with people that do have risks.

Bob Kramer:

Each one of these involves more risk as you go up the scale, but more control over the healthcare dollar. So, you got your total control over the healthcare dollar, but you have more risk. So, I think these things, tolerance for risk, what are your strengths? Who controls the healthcare dollar and scale? Scale is important.

The more risk you're going to take, the more scale becomes absolutely in your local ... It doesn't mean being national, but in your local regional market.

Dan Lindh:

That's a clarification I'd like ... We learned I think, too, as part of our journey is, and we would have been happy not to do this if we could improve the customer life. This isn't about trying to ... You do get some more revenue here that we can reinvest and we're starting to see, see some next year's plan that we'll be starting and soon, we're going to get about a \$3 million reinvestment.

Dan Lindh:

So, there is some value there, but we would have done it if we could have just improved the customers' lives. To your point, what I want to come back to is that we underestimated the importance of scale in a micro market. If we wouldn't have the ability to get to 3,500, 4,000, 5,000 lives and eventually up to 10, I don't think this works.

Bob Kramer:

Let me switch because there are a number of other things I want to be able to touch on before we run out of time. So, let's switch to the role of data and the value of data. Recently, in commenting on the announced seven-year partnership that Humana launched with Microsoft, their Chief Medical Officer and Corporate Officer Dr. Will Shrank said that the next step is to move, which he saw this partnership is enabling them to do, to move beyond the collection of information, to delivery of insights. So, I want to ask you, David, how important is data? Because there has been and will continue to be in this meeting a lot of discussion around data and actual insights and so forth. So, why is that important? How important is data if one is going to play in this value-based world where you're trying to live with better outcomes at lower costs?

David Nash:

Well, it's a great question, and I think you just saw a fantastic example of the importance of the data in Dan's operation. So, let's just think that part through for a minute, then we'll tackle the Humana-Microsoft question.

David Nash:

So, these Allina doctors, well, there now have good information, not just data, actionable information on the patients from your assisted living organization, right? So, I was just thinking instead of the poor nurse, Mr. Jones has a urinary tract infection, has got a fever of 102, he looks bad, ambulance on the way, off to some hospital, and doctors who don't know this person. Family wonders, "Where is dad?" and down the rabbit hole we go. You've totally transformed that model because now, you best believe the Allina physician organization is collecting data to turn it into actionable information.

David Nash:

So, why did Mr. Jones get admitted? So, what meds is he on? Well, let's get on to the electronic record. Let's go look at his diet. Let's go look at upstream at the issues that could have impacted that. You couldn't do any of that unless you were able to connect the dots.

David Nash:

Okay. Back to Humana-Microsoft and, by the way, so full disclosure. I just finished 10 years as a board member of Humana, so I was at the table when a lot of this got started, which has really been a great journey.

Bob Kramer:

We're counting on your insider information.

David Nash:

Yeah. So, I'm off the board now. So, fantastic. Okay. So, a couple of big things. So, Google, Microsoft, Amazon, all are partners with Humana. So, Humana is not playing favorites with any of these large organizations. Why is that? Because the future is all about whoever owns the data and can turn it into actionable information is going to rule the roost. This has to do with ... Let me give you a practical example. So, I'm a primary care general internist. I'm celebrating my 30th anniversary in practice.

David Nash:

So, I'm a dinosaur. No one has ever said to me, "How good a job are you doing at this?" No one has ever closed the feedback loop with me ever. Part one, this is a shock to probably most people. By the way, I know I'm good. Two, I don't even know how many patients I have currently who have heart failure, chronic obstructive lung disease or type one diabetes. Do you think that's a model for the future? Can't work. So, the data that we need, I need a registry.

David Nash:

So, okay, Nash, here are your patients with these various conditions. Oh, and by the way, here are the measures of how you're doing relative to you two guys in my practice, the region and the nation. Now comes Dan as a purchaser of healthcare and he's going to ask in another year or two, "How are those Allina doctors doing?"

David Nash:

Then you're going to say, "Well, a hundred of them are doing ... Here's the bell curve of their performance, and these 10 guys and gals at the end, by the way, we don't want them in the contract next year." So, that's the power of having the data. And the data on the social determinants and the housing, let's go back to me. Great example. 30 years of practice. I've never asked a patient, "What's in your refrigerator?" I mean, shame on me. "How hard was it for you to get to see me today?"

David Nash:

Now, let's fast forward. I have a daughter. I have three kids, but I have a daughter who's a second year attending in medicine at a major academic medical center in Philadelphia. She was trained to ask those questions. She's comfortable with an electronic record. She's never written a handwritten note in a chart. I mean, she's from another world where it's all going to be analysis, data-driven collection.

David Nash:

Bob, data is one thing, actionable information, and when we go to HIMMS on Monday, hopefully, there'll be 35,000 people talking about in the future how do we harness this data to create actionable information.

Bob Kramer:

Okay. Dan-

David Nash:

So, registry function and two years from now, I'd love to go back and hear Dan's update. How did Allina do in delivering that value that you asked me half an hour ago, and what is the patient-centered reaction to that system? Now, that would be exciting data to see.

Bob Kramer:

Good. Dan, briefly on data. How key is data do you feel to the success of what you all are doing? How do you see using data going forward in the future proactively to produce better outcomes for your residents?

Dan Lindh:

Well, data is absolutely key, and I do see it used a number of ways. Today what we're trying to do with data is keep all of our activities focused for the people that are serving. Nursing assistants, housekeepers, training them on different things and showing them data around. One of the leading indicators for us of the effectiveness here is reducing ER visits. So, we're on that really strongly. To measure that, why did they happen? What could have been different? Does all data stuff that get synthesized and shared at all levels of the organization? That would be one example.

Dan Lindh:

Another one that we're working on right now is in pharmaceuticals. I think it's really interesting.

Bob Kramer:

Huge.

Dan Lindh:

We spend a lot of money in pharmaceuticals for the people that we serve, but what I would love to be able to do is have a genome test. We're actually piloting some things right now along with chronic conditions in the medical record run through the gristmill of data to give the physicians, help lead us to what the right pharmaceutical combinations should be. We even do that manually. It's stunning what changes because we see that even with our own physicians. Physicians are interesting because they say, "Just show us the data, and we'd be happy to do it on our own. We're looking at it individually here, but if you could help us see things differently, they're open. We just have to be able to deliver it." Those would be two examples of data at different levels.

David Nash:

So, here's another very tactical piece of this. So, imagine. Mr. Jones from Dan's shop ends up in an Allina hospital, but now, they're sharing an electronic medical record from the assisted living to the acute care setting, and they could see the problem list, they could see the medication list. Then when they make the changes, that will all be visible to the frontline workers when the patient returns to the assisted living. That sounds like a dream come true, instead of the paper handoff and, "Oh, well, we don't have the medication list," and they'd come back and, "That's not the pill I'm on," and off we go. That is a huge source of readmission, all kinds of upstream challenges as well.

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Bob Kramer:

... and wasted-

David Nash:

... and waste, of course. I think, again, even down to the social determinants that you spoke to at the beginning, Bob, imagine if you could capture some of that data, too, and get that into the record where there's 10 companies at least working on how do we get those social determinant information into the chart that influences the kind of care that Dan's team can deliver.

Bob Kramer:

All right. I want to shift for a moment, too, just before I'm going to do a lightning round of questions, but before I do that, I'm sitting here, I'm hearing tons about healthcare, healthcare discussion. I've got an internist here, MD, also MBA sitting to my left and I'm thinking, again, "Wait a second. What happened to the original value proposition of senior living?" Are we moving away from hospitality? Are we moving away from a focus on life engagement, life enrichment? Is this an either or proposition or is it a both and, Dan?

Dan Lindh:

It's a both and, and in our shop, I like to say to our people, I do say to our people the core is in the life enrichment, it's in the wellness, it's in helping people lead purposeful lives and to have high engagement in what they do to serve at the top of, live at the top of that Maslow's hierarchy of super, the high engaged. Even internally, we talk about the stuff we're talking about here as an add-on to the core. It's not the core. It will never be the core. It's an add-on to the core. Keep that perspective in mind.

Dan Lindh:

It also adds a lot of value to that core. People's lives are better because of it. So, my answer would be it's a both and with the weight still being about 80% in the things we've already always done and maybe 20%, pick a percent, a lighter weight to this kind of stuff, just one person's view.

Bob Kramer:

Good. Certainly one that I would agree with. Let me just ... I want to do some lightning round questions and make sure we get to them. So, in these questions, I'm looking for brief, very brief answers, yes, no or maybe a number. We heard earlier from Brian, in the early 2020 where we are now, 34% of seniors are in Medicare advantage plans. 10 years from now in 2030, the youngest boomer will have just turned 66. What percentage of seniors in 2030 do you believe will be in Medicare advantage plans? David?

David Nash:

80%.

Bob Kramer:

80%.

David Nash:

Absolutely.

Bob Kramer:

Dan?

Dan Lindh:

60%.

Bob Kramer:

60%. So, we're at 34% today. You're at 80%, you're at 60%. Again, folks that are going to be at full capitated risk themselves for that healthcare dollar spend, and they're going to care an awful lot about those high risk, high need individuals, those frail elders with multiple chronic conditions and ADL needs living in your buildings.

David Nash:

Bob, Medicare advantage, that's what's connecting the dots and the lining incentives to make this entire thing work. It's the only thing that our whole industry, acute, post-acute, everybody can point to healthcare industry that's working. So, I'm very optimistic that no matter what happens in November, we're going to keep moving and more folks are going to want Medicare advantage.

David Nash:

By the way, in our house, since we're a year away from this, this is an important decision, really.

Bob Kramer:

We'll stay tuned. We'll have you back.

David Nash:

Stay tuned. That's right.

Bob Kramer:

Okay. In 2025, will independent living, assisted living, and memory care providers be able to survive and compete if they do not have real-time electronic health records that are accessible to other care providers who touch and serve their residents? Yes or no?

Dan Lindh:

No. I would say they need to be there. If they're not there, they're going to be disadvantaged. I look long-term for the government to do what Israel or Finland have done, which basically everybody's got an electronic record that's universal, and the decision comes right up our hands. In the meantime, we got to keep moving that way.

Bob Kramer:

David?

David Nash:

Yeah. Well, that was a great answer. You're looking for a yes/no. I would say most likely yes. Right. Just think about it. Israel is a great example, right? Eight and a half million people, so one city in America, but

basically, four HMOs. Each HMO has two million Israeli citizens. They're all on one same electronic backbone. On top of that is some synthetic tools. I mean, it's amazing what they're able to do.

Bob Kramer:

All right. Third, within five years, will a health insurer have acquired or developed a seniors housing platform? Yes or no? Dan?

Dan Lindh:

Yes. Some versions of it are already in process, I was pleased be part of the NIC study, middle income. One of the reasons we're doing this is we feel we cannot be successful in the middle income market without these assets.

David Nash:

That's a great question. To me, I think, again, the Humana-Kindred relationship, which is admittedly complicated and is not specifically the bricks and mortar piece, but over time, you have to believe I would say there's further convergence, and I'm going to introduce at the end here another jargon term. So, we talk about in our marketplace in Philadelphia the emergence of the payvider. Terrible word, I get it, but the provider-payer convergence, and because of that, the move across the entire spectrum, which has to involve this audience, there's no doubt in my mind and I think Humana-Kindred is a good example.

David Nash:

Let's give a practical piece of that. Imagine if I have Medicare advantage patients, and they're hospitalized, and I have a global capitated situation. If you could reduce my readmission penalty by putting my patient in some kind of Kindred facility instead of a readmission, and I'm not penalized, everybody wins, the family, the patient, the healthcare system. That's the kind of thinking that we're going to need for the future. I think this crowd definitely needs to be a part of that.

Bob Kramer:

Okay. Next, let me just ... Let's see if I can put this up. Okay. This slide basically shows from Medicare advantage plans supplemental benefits are significantly expanding. Traditionally, they'd been in areas of vision, fitness, hearing, and dental. Now, particularly with the special supplemental benefits for the chronically ill act, and then the moves by CMS first in '19 and especially for 2020 plans, we've seen a significant expansion to the things over-the-counter medicines, telehealth, meals, transportation, acupuncture, wellness and fitness, in-home support, home modifications.

Bob Kramer:

You see, some of you probably can't read it, but you see the percentage right now of plans offering these benefits. I want to ask you, which of these benefits do you feel is going to grow the most and pick up in the new and emerging in terms of being offered by MA plans? Dan?

Dan Lindh:

I think real, basically, meals and transportation the most because people who are isolated are very difficult to get out. It's just important to their quality of life and function. Behind that, I would put telehealth, telemedicine.

Bob Kramer:

David?

David Nash:

Yeah. So, I'm telehealth and transportation, telehealth being way ahead. Again, if you look around the country, Humana, Cigna, CVS Aetna, all of them have activities focused on improving the home connectivity and look, seniors, we know how tough that can be, but with changes in the technology, all kinds of ways to communicate, close that feedback loop. That's going to be the biggest part.

Bob Kramer:

Last two questions. Will senior housing providers see a significant increase in health and supportive services for their residents being paid for through Medicare advantage in the next three to five years, a significant increase?

Dan Lindh:

Yes.

David Nash:

Yes.

Bob Kramer:

Yes.

David Nash:

Because we know it works.

Bob Kramer:

Okay. Lastly, do you believe a seniors housing product with a Medicare advantage plan wrapped around it for residents will be key to meeting the needs of the exploding population of middle income seniors, who are unable to afford much of the private pay senior living options out there today? Dan?

Dan Lindh:

Yes.

Bob Kramer:

You all are really pursuing a strategy on that.

Dan Lindh:

We're really pursuing a strategy and a lot of work in it. One of the real risks we are trying to manage when you move into that space is people moving into the safety net and being able to commit to meeting their needs. I don't see a scenario where you can do it without having a strong Medicare advantage plan behind you.

Bob Kramer:

David?

David Nash:

Absolutely. I agree. That's why I said 80%.

Bob Kramer:

Terrific. Well, we could go on, but Brian won't let me. It's time to move to a break. I'm going to invite Brian to come up. Really appreciate your attention. I hope you've seen that we're not saying, we're saying that you have an option to take advantage of something that's going to benefit your residents enormously, is going to benefit you in terms of longer length of stay and happier, healthier residents able to stay in your setting, and is going to benefit people who are going to want to partner with you if you're open to doing this.

Bob Kramer:

The other side of it again is to close with there are others who are harvesting data about frail elders, who will move in to seize that market if we don't take ... We have an embedded advantage. We monitor 24/7. We've got staff already. Lifestyle management is what we do every day. It's in our DNA. Now, all of a sudden, the health world has woken up and said, "This is really important to good outcomes." What an opportunity for us. Please join me in thanking my fellow panelists.

Brian:

Bob, Dr. Nash, and Dan, thank you so much. I know we could literally keep going, but we do also have sessions here in 15 more minutes. So, sincerely appreciate your time and the insight you've provided, particularly some of the data and stats that were shared here as well. So, again, thank you very much.

Brian:

So, breakout sessions will start in about 15 minutes. We'll continue this discussion through those breakout sessions. Then, of course, we'll have another 15-minute break, and 11:15 will be our second set of breakout sessions. We'll then be back here at 12:30 for our lunch, where we'll have Andy Waldeck, a partner with Innosight, provide us with his thoughts on innovation and disruption of the seniors housing and healthcare space. So, thank you very much again for joining us. Enjoy the sessions, and enjoy your networking.