

Jason: I'd like to just ... I'll introduce myself, go through a few slides, and introduce the panel. My name is Jason Feuerman, I'm senior vice president with Genesis Healthcare, a large post acute provider operating in about 30 states. I come to the industry from the managed care world having run managed care organization for about 17 years, before selling it, at Genesis working with a lot of value based care initiatives, including bundle payment [00:00:30] Medicare shared savings. Brian, you want to introduce yourself?

Brian: Yeah, I'm Brian Fuller, I'm the chief strategy officer for Great Lakes Caring. We're an in-home, home health hospice and personal care services business in 12 states based in the mid-West and the Northeast. And we are a Blue Wolf Capital portfolio company.

Peter: I'm Peter Longo, I'm a managing partner and principal and Cantex Continuing Care Network. We're fully integrated post acute network based here in Texas celebrating our 40th anniversary [00:01:00] this year. We own and operate a privately held company that own and operate all of our own facilities, and extending into the community with our home and community based services. And delighted to be here at the conference.

Kelsey: Hi, good afternoon. I'm Kelsey Millard, I lead all of the health system partnership work at Honor. Honor is a personal care services home care company based in San Francisco. We're venture backed, we've raised a series A and series B claiming to about \$60 million. We operate in three states currently, California, [00:01:30] Texas here, actually in Dallas, and also New Mexico. We approach the market in a pretty different way from traditional home care in that we use technology to actually manage our workflow for our employed workforce. We actually employ our caregivers that are part of platform. And really delighted to be here today.

Jason: Thank you. You can see here what we're going to be talking about today. I think it's going to be really important, and we'll get into discussion at first about why these networks are even [00:02:00] forming. And so, with that I'd like to open it up and say there have been a lot of discussions for the last couple years throughout the industry about the impact and networks at meetings just like this. These conversations are now beginning to shift from purely establishing a narrowed or preferred network, to an expanded concept of network, which includes care management, partnerships and other non-Medicare fee for service benefits that prove valuable in network relationships [00:02:30] and managing better outcomes and utilization.

In today's session we'll explore this new world order, that's my term, but it is really a new world that we ventured into, where our distribution channel is really demanding more than ever that we produce quality outcomes, and we improve quality. An important takeaway from today will be the impact of transparency on a post acute industry, and how providers are positioning themselves in order to create successful [00:03:00] partnership in this ever evolving world of value based care. With that, I'd like to give the panelists an opportunity to really address, and maybe we'll just start with Brian here, and from your perspective what's happening out there that's causing these networks to form?

Brian: Yeah, so a couple ... Networks are not new, right, they've been around in healthcare for a very long time. I think a couple of things have changes the face of networks if we just look at present [00:03:30] day. One, just being honest because we're all colleagues here, we don't do anything unless the money incentivizes us to do it, so I think the fundamental reason that networks are forming is because the financial incentives to engage in preferred narrow priority networks, whatever nomenclature you want to attach to it, is because the financial incentives are aligned to do so, and those financial incentives have grown over time. I think we're in a very different place three years ago [00:04:00] than we are today because those financial incentives continue to have kind of an additive impact across the industry, whether you're talking about MACRA or alternative payment models or other things that are kind of driving the adoption in the incentives related to risk.

The second reason I see networks forming is really operational efficiency from a number of different perspectives. The first is health systems have generally more access to capital, more resources than most post acute [00:04:30] care providers. They could go out and do what they decide to do, the question is how well can they do it and how operationally efficient can they do it? And so, you saw health systems two and three years ago, for example, go out and establish a care coordination or a care navigation department, they hired tons of FTEs, they sent them out into the world, and it was extremely costly to the health system or to the ACO and they slowly realized they cannot do it as well as other partners can do it in the service delivery model.

[00:05:00] And then within the health systems kind of core operations they've increasingly come into the realization that they can't work with 75 skilled nursing facilities, it is not possible to meaningfully change the relationship with 75 SNFs and 32 home help agencies and whoever else they have in their community caring for their patients. That also has dictated kind of this move towards working with a narrower number of providers and choosing partners, which I think we'll discuss today, how the nature [00:05:30] of those partnerships are certainly evolving and changing as well.

Jason: Great, thanks. Peter?

Peter: I think we're seeing quite a transformation in terms of networks. We've had a great deal of discussion within our panel as we prepared for today and sort of talking about how the concept has evolved from a focus over the last five years or so, I'd say, of development of referral network. We've all been very, very focused as providers on assuring that we have strong, longstanding, sticky [00:06:00] relationships with our referral partners, whether they be hospitals, physicians, ACOs, other groups that we're working with. It appears that over the last couple of years some of the emphasis has shifted from just purely development of referral networks to development of service delivery networks that are really beginning to expand and extend out the reach of providers really in every place, whether you're a senior housing provider or a skilled nursing provider or home health [00:06:30] or hospice or any other type of provider, of really extending out to see if you can begin to cover more services within your own network with the goal of providing a more seamless experience for the patient and for the payer in terms of the way a patient is cared for an entire episode of care.

With that, beyond all of the focus that we've had on how do we successful reform referral networks and the focus on the traditional quality metrics we've all been thinking about and managing, both length of stay [00:07:00] and minutes of service and therapy, and five star ratings and so forth, all the things that we feel solidify our position with our referral network partners, really stepping out and looking more at how do we team up with others to bring under our own tent, and then that way assure a more seamless and high quality experience and better outcome for the patient within one service network? And we've seen it in different ways at both the public company level where we've seen companies [00:07:30] literally begin to collapse services, and we saw Kindred until Kindred sort of coming apart now, but was putting together under one roof a lot of those pieces. We've seen Encompass and Health South bring together IRF and rehab oriented services with home health services, sort of that direct investment in other platforms.

At the regional level we've really seen all sorts of partnerships begin to evolve that sometimes are direct investments, the same way the public companies are doing, and sometimes they're more capital-like contractual or joint venture arrangements [00:08:00] where we're literally sitting down together at tables and figuring out how we can co-brand and present in one seamless way a series of products that will ensure a better episodic stay for the patient. I think there's been quite an evolution in terms of the network formation.

Jason: Yeah, and I want to get back to that in a minute, but before we do, Kelsey, your thoughts?

Kelsey: Yeah, I mean I completely agree with Brian and Peter's conversation around the transition of just a referral network to actual a service network, and fundamentally, what's changing there is the expectations. We now have a [00:08:30] shift of expectation of data exchange and response rate and protocols as to what happens if a patient falls, so we have escalation strategies as part of these partnerships that are expanding beyond the typical fee for service providers and including folks like Honor as a non-reimbursable service, but out-of-pocket expenditure for most patients ... We're actually stepping forward and participating in these networks as they form. Ancillary services and more of the community based organization services are actually stepping forward and participating in these as well [00:09:00] as a way to maintain their market share, but also to contribute because of the desire of these upstream risk based providers to actually have reach and connectivity and control leveraging other resources that they actually don't want to acquire themselves.

Jason: Good, thanks. Peter, I want to get back to something that you said regarding post acute networks and referral networks versus service networks. And I think it's very intuitive what a referral network is, and most people are familiar with that. Can you go a little bit deeper into the [00:09:30] service network and what you're either doing or thinking about doing? What the capital investment looks like? As you well know, it's a cash strapped industry and, to Brian's point, the financial incentives are really misaligned and perverse, so how do you get to where you hope to go to through that service network?

Peter: Well, I think it's a series of steps, it's almost a mindset. It's about being nimble and flexible and trying to really get to the bottom of what you need to do to serve that patient best [00:10:00] over an episode, which typically the financial success and the clinical success often align, we find that, so it is getting to the bottom of that, and then assuring that your service offerings have as many of the pieces of the puzzle as necessary. In our case we've sort of chosen to sort of stay on the non-acute side of the divide. There are certainly providers that are doing both, specialty hospitals and in-patient long term care and home health, for us we sort of decided to stay out of purely acute. And that really meant a number [00:10:30] of years ago on a direct investment basis, both Denovo and Inquisitive, in terms of acquiring home health and hospice agencies, that were servicing of our skilled nursing facilities. We weren't acquiring or starting Denovo willy-nilly around the country, we were really focused on the markets where we had intense market presence in our skilled nursing facilities and radiating out, enveloping those facilities with extending services in the home health and hospice areas. Both medical services, but at an at home basis or hospice in [00:11:00] our facilities.

Beyond that, in the most recent realm we've really said, "But we need to go further than that." We began to talk to folks like Honor about how do we take non-medical home care and how do we partner perhaps rather than in a headwinds time like it is right now, we're seeing margin compression, a lot of pressure on in-patient skilled nursing operations, maybe not as eager to commit a huge amount of capital to those businesses, and maybe seeing as hospitals have over the years that you don't need to be in every business [00:11:30] yourself, that sometimes you can achieve the same episodic results by just partnering. We think, and we've had some success in being creative and getting around the table with folks like Honor, to say, "Can we take that home care service and add it on and co-brand it?" On the pharmacy side, can we take the pharmacy out of just the in-patient provision of our pharmacy, but take that home. Is it necessarily the case that pharmacy delivery has to stop [00:12:00] upon discharge from our SNFs or our home health agencies? Not necessarily, that can go on.

Are there physician relationships, are there capital-like partnerships, contractual or other partnerships? Physicians do a lot of the driving with MACRA, sort of a whole new potential for the way physicians are going to play into the way referrals flow. Are there ways to partner with them? I think it is overall a mindset about partnering. And I failed to mention really one other very important one is that, for companies that are considering getting into the insurance realm and forming their own ISNP [00:12:30] or DSNP, you're going to be wanting to talk to a company that has experience in doing that to help you do that. Another potential partner. And there may be some co-investment in a joint venture exercise, there might be just a contractual relationship, we've seen it work different ways, but those are all the kinds of partners as we talk about service delivery partners and networks as opposed to referral networks that we're coming into contact with.

Jason: And as you think about developing that service network, as I think about ... Home health is [00:13:00] a very simple example. A lot of hospitals, at least in part of the country that I operate in, have home health so it's a very dangerous place to kind of dip your toes.

How do you navigate through where there are potential conflicts with your primary distribution channel?

Peter: It's a great question, and one that I think a lot of people spent a lot of time thinking about. I think, as always, it's about going gently, I think it's about learning about and understanding who your partners are, having transparent conversations with them [00:13:30] about what their goals are in their business lines, being frank, as we've been on many occasions, with our hospital partners, "Look, we're already in the home health and hospice business in this market, you are too, let's just light that upfront. What we can tell you as a hospital partner is that when we know as you're admitting to us and we're able to better identify your patients, if we've got a pre-agreed protocol that that patient is going to stay within your network, and we will respect that, and we ask the same from you, that when one of our patients [00:14:00] comes to you, that you respect our network." I do think it's important that we try to get out of this hierarchy mentality where the hospital sort of being a bigger kahuna, if you will, gets to have a bigger say at the table. I think it's everything about presence and the way you present yourself to say, "That really can't be the case." We've got to be equal in respecting partners, transparent partners, but recognize that conflict exists upfront so you can deal with it.

Jason: Great.

Brian: I think you also ...

Kelsey: But Peter ...

Brian: Go head.

Kelsey: Well, I mean I think you make a good point, is that a lot of us come to this world with this perspective that the hospital [00:14:30] is the head honcho and we're just feeding off of them. And what I think we have to realize as an industry, it's like the AL ILs, they should be the feeding point, and they are actually the control point that's actually managing all of these transitions of care in and out. And so, we all have to put on a little different hat here and instead of saying we're just at the receiving end and the whim and we're just begging the hospital to make sure that this patient comes back to us, we should demand that and we should have service level agreements that actually respect the patient's choice that this is where they want to be. And we could actually help guide and facilitate [00:15:00] that care can happen even in AL and ILs and doesn't have to go to the hospital this time. I think there is this kind of like shift of ... When we talk about shift in network I think people make the assumption that networks start at the hospital, and that's an old way of thinking. And I think we have to update our perspective and actually own the fact that we do own a lot of control in this, and now we can actually start to leverage it.

Jason: Brian, you were going to say something but before you do ...

Brian: Oh, that was a much better point than mine.

Jason: Well, I'm actually going to ask you for a follow-on. [00:15:30] If you're a senior living provider, how does the move of the value based care impact your worlds, and what opportunities do you see as ... I know you're not a senior living provider but we've all been in the industry for a long time, what opportunities do you see for that senior living provider? I think it flows well in Kelsey's response.

Brian: I think a couple things. One, I think it depends, right? In very few market in the country have we reached that tipping point where [00:16:00] service networks, at risk payment, total cost of care contracts are the majority of the volume and/or the revenue in the delivery system in a market. And even further, if you go into a health system, a few health systems have crossed that threshold. I think we still are in a world, and I know this sounds like repeat from meetings like this, but markets are in very different places and individual health systems are in very different health places. I think the assessment of your opportunity and your dynamic is a very market specific [00:16:30] exercise for you based on where you currently operate. Having said that, I do think we can learn some things from the journey on the post acute network development side. And a couple of observations if I was a senior living operator, I would be looking to match kind of this journey in where the current state sits on a few different dimensions.

One, the sophistication has increased. Years ago networks were judged based on five star rating [00:17:00] system, readmission rates, and a couple of other metrics, many of which were either reported by the SNFs or publicly available on sites likes Nursing Compare, we've moved beyond that where you see now claims based data analytics happening, you see score cards that are very comprehensive that create waiting and scoring. And so the data game, if you will, has elevated in the post acute side. If I'm missing your living operator I need to put my mind in that same frame of reference [00:17:30] of what's happening to the residents on my campus, what risk factors are they moving into, are they rising risk or high risk, how do I keep tabs on their change of status, how do I keep tabs on the amount of utilization throughout the ... All of the things that post acute providers are monitoring, because if you're going to manage care and manage health, you've got to have that data at your fingertips and then know what to do with it. And we've seen that sophistication grow over time on the post acute side. [00:18:00] Similarly, the dollars are going up.

Jason: Yeah.

Brian: If you're talking about service delivery network, now there is collectively more dollars in the system, either through savings opportunities or risk profiles, for you to play a role that generates a real return for the partner. Secondly, I would say everyone is getting more serious about these networks, so whether it's tracking utilization of the network, where volume is going, how the [00:18:30] volume gets funneled there. Even I know in various roles I've played over the years. This whole idea of patient choice keeps coming up and is like an immediate block by either internal counsel or a hospital case management department director. And you're starting to see the concept in application of patient choice evolve and change to be more network friendly, whether that's referral or service delivery, such that you can actually route patients [00:19:00] to your network and not be in violation of patient choice laws. MedPAC actually just took up

this issue in their most recent meeting where they're talking about now transforming the hospital discharge planning process. There's a PowerPoint from their latest meeting if you want to go view their concepts around this.

And then finally, I would say, which I think Kelsey was going here and it was one of my points, if I'm a senior living provider I'm coming to the table from the perspective of I'm the one that owns [00:19:30] the relationship with the senior, those people are on my campus, I have responsibility, I'm home base for them. And so, how do I want to manage their care? What role do I want to play? How does that intersect with the physician network, the health systems in the community? But you as the relationship owner I think is a very powerful way for you to come at that conversation, however, I will say if we just, again, [00:20:00] learn something from the post acute side, health systems aren't going to come to you with this idea, so you're going to have to be proactive in that outreach. Everything from the business concept to the economics, to what services are included and excluded, to how that's going to line up with what accountability you're going to take, kind of all that [inaudible 00:20:20]. You're going to have to take that to the health system in a pretty baked kind of way and let them react to it, because they're not going to come to you. And if they do, [00:20:30] they certainly aren't going to have the same level of thought and rigor that you would put into it.

Jason: Agreed.

Peter: Jason, if I could add to that?

Jason: Yeah, please, please.

Peter: So many great points that Brian just made, and it makes me think of a bit of a debate we had at the planning sessions for this conference and dealing with the whole idea of care coordination and the way value is created now. I think there's a huge opportunity that's not being exploited yet for senior housing providers and more traditional SNF and home health and hospice providers to collaborate. But there's a tension around [00:21:00] that as well. I think for those of us that have been around the industry long time, we look back to the 80's and the period when the AL and IL sort sectors sort of came into being, and really siphoned off a huge population from SNFs at the time into entirely new settings that were not medical by definition, and that part of the way that they got away from the stigma of being in a nursing home and became comfortable to be in an AL setting was because it wasn't a nursing home and it wasn't medical. And so, there's a great fear, at least I sensed at our planning sessions [00:21:30] on the part of the senior housing, is "Do not medicalize us."

Kelsey: Mm-hmm (affirmative).

Peter: And I kind of hear that on the one hand and I understand that fear, but on the other hand I feel like we're really in a moment where we need to be collaborative, and to the extent that senior housing providers are looking to exploit some of what Brian was saying about being sensitive to the care, the medical care that their patients and that population that they own is getting, one of the ways to do that is to partner with a

provider who's on the SNF home health hospice side to really collaborate on [00:22:00] what each of you does best. We're medical providers really, and we take our business on the road in home health and hospice, so we provide it in our own buildings when we're doing it in SNFs.

We'd love to partner, we've had conversations with senior housing providers about "How do we partner? You guys have that beautiful long term setting where those patients, residents for you, live but there's a way to capitalize partner on a lot of those initiatives and results better episodic care that we can be looking together for the triggers for your resident and senior housing setting [00:22:30] that might suggest some medical intervention where we can be right there and sort of on top of that patient so that we can deliver that care in a seamless way and get them back to you." That scenario that's really right for exploitation and it's just starting to get going now.

Jason: Yeah. That brings up ... Coming out of the [inaudible 00:22:48] world I always think about medical care being paid for by either Medicare or in many cases Medicaid. And, Kelsey, I know you're at Honor now, and we've heard the name of your company [00:23:00] several times at the beginning of the session, and more and more for me over the last probably six months I've run into companies like Honor that are providing non-Medicare really private paid based non-medical care to really at risk seniors in their home. And maybe you can talk about what you're doing and the approach there.

Kelsey: Yeah. Well, let's first start to talk about what we're actually doing inside the institutional settings, inside the skilled nursing facilities, [00:23:30] inside even the residential settings. What was really interesting as I started at Honor two and a half years ago is that skilled nursing facilities started approaching us and saying, "Our hospital network is requiring us to take patients who are sicker than we're able to take. Can you guys come and provide 24/7 staffing for us?" Now we are now staffing inside a skilled nursing facility so that the skilled nursing facility can take on patients of higher acuity so they can keep their beds filled of paying patients and actually transition them through as their [00:24:00] length of stay is getting compressed. That's one really interesting use case that we didn't expect. We were building Honor to serve seniors inside their homes and we quickly found ourselves inside the skilled nursing facility settings. That's been really important for us because it is an at risk population, and we're actually able to have an impact. We can reduce readmissions from SNFs and then we can actually continue that transition into the home setting with the continuity of an Honor care professional. That's one use case. Another use case that was pretty shocking to me as I was coming into home [00:24:30] care, specifically as an industry after being at naviHealth and building out post acute care, and that's where we first met Jason, as we were talking ...

Jason: Not a good experience.

Kelsey: ... Yeah, as we were talking about risk environments as opposed to acute care providers and cutting in post acute care providers. But the lack of sophistication that actually exists on behalf of ... And this is kind of a bold statement here, but on behalf of the operators of AIs, is pretty astounding. Most AIs don't have any idea who's coming in and

out of their own facility, [00:25:00] yet they're managing everything there, and I was completely dumbfounded by this. I was like, "How can you not know who's coming in and out of your facility to take care of your residents?" That's been another area of a lot of progression, especially in the California markets where we've started to work with AIs and ILs and actually give them transparency as to what Honor care pros are coming in, their whole certifications and providing care inside those settings.

The two other unique things that have come up more recently as we've started to talk about network design [00:25:30] and participating in kind of service networks inside the markets of which we operate, is that we now actually attend the quarterly meetings with the home health, with the hospice providers, with the hospitals, with the SNFs that are stemming from the risk based taker in the community. We've been able to successfully receive some waivers from CMS to allow these providers to actually pay for care that is, again, typically not covered as a result of this risk based arrangement that this provider group is in. That's been a really fun way to actually [00:26:00] tap into a population that actually really needs this service, and there's finally incentives and alignment around those dollars to allow them to pay for it and recoup the savings.

The fourth area that I'll touch on on our partnership work is really around the existing home care industry. You guys know a little bit about it, it's hyper fragmented, it's ma and pa shops, it's great, it's very local, and we don't want it to lose that feel because that's the feel of trust that we all depend on for sourcing care for our family in fact. [00:26:30] And what we started to do is realize that home care companies typically kind of cap out on their operational capabilities AT about \$1 to \$3 million ARR, and then they can't grow because it costs them more to grow than it actually does to generate revenue.

And so, we've started to partner with the home care companies where they actually become ... They stay the front end and they have all of the referral relationships, which this is very much a relationship based business and we're not looking to disrupt that, but we actually provide all of the backend support. Their workforce [00:27:00] becomes Honor's workforce, and then they use Honor's technology and then we're able to provide more transparency to the referral partners and to the families as to what's happening within the care setting based on the communication mechanisms that we have set up. Those are four examples that two and a half years ago when I started at Honor I would have never come up with, but because of the direction of the market and the pace of which people want to have access to the services without having to buy them or build them themselves has rapidly [00:27:30] kind of evolved into Honor's operating models today.

Jason: Great, great.

Peter: And one of the great things about Honor, Kelsey and I have talked about these relationships at some length the last year, is the tech enabled component. It takes sort of home care, which is wonderful in its mom-and-pop evocation in most of the countries, but Honor's really sort of taking it to a different level in having that tech enabled component. You can begin to think about this as a private pay service that ...

And those of us that are used to being paid [00:28:00] primarily by Medicare and Medicaid and sort of struggling sometimes with private pay receivables, there's sort of a possibility for a more uber type experience for home care so that you can sort of order individual segments of service for your parent on a phone where your credit card is already registered so that it's sort of an easier thing to contract and pay form and doesn't really involve the same kind of receivables issues. It's sort of a whole way to wrap that around.

The other interesting discussions that can go on when you capitalize partner in this way [00:28:30] is all the things that were being pressed by our payers for in terms of watching our patients post-discharge and by CMS is a policy priority about how many days post-discharge can you still have your finger on that patient? Well, home care represents an enormous opportunity to do that, because the care pro in Honor or the care professional at any other home health or home care agency is there with the discharge patient doing regular day to day tasks, but is in a position to look for a change in weight or are [00:29:00] their medications actually being taken, are those little pill containers being refilled, was that doctor note on the refrigerator actually did they attend that? They can through just sort of being trained be observant for things that are going to help us have that reach post-discharge and are going to help us get to better levels on an RTA than we ever have been before. That's a very exciting possibility, and these partnerships make that possible.

Jason: Yeah.

Kelsey: I think you bring up a good point, Peter, though that the development of the infrastructure to actually allow networks to perform is rapidly [00:29:30] evolving. We have folks like patient ping, right, that are sending ADT files amongst an entire network of providers to say, "Your patients about to be discharged" to "They're admitted." And so, I think equally important to the development of the relationships and the service level agreements is actually what is the underlying infrastructure and piping that's allowing these to actually succeed? And it turns out it's some basic technology along the way.

Jason: Yeah, good. And, Brian, from your perspective, besides things like Honor and [00:30:00] other things we've talked about, what new models are you seeing out there that are very nontraditional? Because I consider something like Honor to be nontraditional. Any time you get into the consumer based world of healthcare ... And we're not going to see it in our generation but it will eventually get here, but it's far from here right now.

Brian: I think we will see it in our generation, actually. First, there is a lot of equity being put into these new, whatever [00:30:30] you call them, service delivery model companies, disruptors, they've been at various kind of names attached to them, a significant amount of equity. If you want any proof point to the business case validity, watch where the dollars are flowing. And there's a lot of dollars right now flowing into these new care management service delivery companies. But, again, they're not new. Companies like naviHealth, naviHealth is a service delivery company that six, seven, [00:31:00] eight years ago was disrupting the post acute industry and everyone was ho-humming in a

room like this full of SNF operators because of what they were doing, and the reality is they were doing nothing that a SNF operator couldn't do, they just stepped in and took the role and took the reigns. And so, entities like naviHealth have been around, entities like Aspire, who are doing similar on the palliative and hospice side, playing a very critical role, quite frankly, a gap in the healthcare [00:31:30] delivery system, but not a gap that any provider couldn't fill, it's just providers haven't stepped into that role in their community.

I think there's a couple of interesting kind of subsequent waves now that are happening. One wave that appears to be burgeoning is this whole concept of 10 percent being 60 percent of the cost. You see these really high costs chronic care management companies emerge, companies like GenMed and Landmark where they're [00:32:00] really going after the chronically ill, the highest cost patients, and they're wrapping around a very high touch management model around them. Another one that kind of seems to be sitting on deck, if you will, and not yet at home plate is behavioral health. There's, again, a lot of equity in behavioral health models, so that's another service delivery model. But right now ... I was having a conversation actually before this session started, these models appear to be very niche, so they go after one [00:32:30] very microcosm of the healthcare system rather than looking at patient from age 60 to age 90, and how does that progression of the patient's health look?

Instead, they're targeting very specific aspects of wither the care delivery system and where it's inefficient or very specific issues within the care of the patient and/or their condition, and they're targeting the business model around those. That kind of [inaudible 00:33:00] model [00:33:00] where you're connecting all the pieces has not emerged yet, but a lot of these niche players now are disrupting the industry. What I'll say to senior living providers, "If you don't want to be disrupted in your community then step into that role, because if it hasn't already happened it's a matter of when, not if, that someone's going to step into the role that you could have played, because we're seeing it in lots of communities across the country."

Jason: I think it's a really valid point and it's a very big wave [00:33:30] that's happening out there. And we all follow the money when it comes to private equity, we know where it's going. Do you see it as the next big threat, not just as senior living, but the post acute providers?

Brian: Oh, yeah.

Jason: Yeah.

Brian: I mean, you can look at the history. When you have one of these disruptors or service delivery models come into a market, volume goes down and shifts to lower cost setting, utilization pressures start to happen, on top of that expectations for performance [00:34:00] increase. You kind of get hit on both sides of the income statement, if you will, revenue's going down and expenses are going up.

Jason: Not a good model.

Peter: It's sort of a classic model, this disintermediation that you're describing, Brian, that goes on as the market begins to disrupt, and then folks realize what you just pointed out, is that you really can do it yourself. So when a middle man emerges to start handling something that was obvious you should have been handling yourself, you learn over time to do it.

Brian: That's right.

Peter: We see these models from sectors that completely afar [00:34:30] from us, whether it's Walmart going into the market and trying to be Amazon-like, it's another example at a different level but something similar that we can do, which was to have a health and remedy coming into our markets and doing certain things. We said, "Gee, we could do that. We could probably do it a lot more efficiently, and who do we need to be talking to going directly to the payer source to get there?"

Brian: Exactly.

Peter: And I think one of the other partners we haven't really talked about very much is the physicians. And I know that Genesis is there, but for some reason we've struggled as providers in really having strong physician relationships. [00:35:00] And you mentioned GenMed, which is such a great example, but a localized example in Florida primarily. And I think that model is something that's an opportunity for most providers, whether we're healthcare providers as in SNPs or senior housing providers, to begin to partner with specialty physician practices who are really focused on the populations we serve as a way of improving the way populations are managed in their care. And because GenMed is sort of a [00:35:30] special geographic sort of location, there's really a great opportunity in states like Texas and throughout the country in many other states to be looking for physicians that are really oriented to taking on those high touch patients. It's a whole practice niche that hasn't been exploited too much yet.

Brian: That's a great point. Kelsey pointed out by saying health system centric thinking is an old way of thinking, and that we defaulted right back into the very hospital centric conversation. That's a great point on physicians, I think, for a couple of reason, [00:36:00] at least in my experience. One, MACRA and other things are elevating physicians to trump, if you will, health systems in a lot of ways.

Jason: And BCI advance, yeah.

Brian: That's right. They are moving to a more powerful position in a lot of these different policy changes, so I think that's an important trend to watch. And then other is we talked about conflicting incentives, there are many, many, many less conflicting incentives on the physician practice side than when you go to a hospital. They don't have the big, shiny glass buildings that sit as huge numbers on their [00:36:30] income statement where they've got to fill them to make themselves whole, physicians can disrupt what that care delivery system looks like and don't have to fill the Eds and the heads in the beds. And so, the incentives are a lot cleaner, if you will, and a lot more aligned on the physician practice side we found.

Jason: Yeah, we certainly believe that. But all of this raises an issue. And I know none of us on stage today are investors, but we probably have investors out in the audience. [00:37:00] How should an investor be looking at all of this? We're talking about the disruption that's taking place, we're talking about investments that need to take place. There's a lot of properties, whether it's IL and ALs or whether it's post acute, that are being traded from one party to the next. How should those investors be thinking about this and taking it into account in their evaluation in how they look at the opportunity for this business, and [00:37:30] really how well positioned is it?

Kelsey: I think there's kind of two investor angles that I'll touch on, one is private equity, and then I live in San Francisco so I have to talk about Silicon Valley and venture money as well. And on the private equity side I think what we're seeing really take a huge stride forward again is not folks expecting just bricks and mortar, but they're expecting bricks and mortar and services. People don't want to just invest in AL/ILs, they want AL/ILs who actually have some care coordination capabilities, who have some [00:38:00] tech capabilities, who have some partnerships that actually make them more than a bricks and mortar building, which could easily be equivalent to a hospital essentially. They're looking for that expansive suite, and we're actually going to talk tomorrow on a panel about labor and how investors are starting to think about labor models, and actually when you do make an investment you're not just investing in the wallpaper and the carpet but you're actually investing in the labor that's there, because that's actually what's driving residential happiness and sustainability and longevity of your residents.

I think that's one area that [00:38:30] really rapidly moving away from just the traditional bricks and mortar with the beautiful front entryway and ... Which I know you guys have beautiful facilities, but you do a lot in those facilities and that's what actually makes that a really rich property. And then I think on the venture side, no one's investing in bricks and mortar. We even see some of these pop-up clinics that are appearing that can service seniors and are extending into the senior community like Forward and City Block, which has been out [00:39:00] of Sidewalk Labs focused on eligibles, and their bricks and mortar are really light. And so, there's a lot of venture money who's interested in actually building the pipeline and the pipe and the ways to connect all of these folks together, and that's a huge area of interest for the venture community.

Peter: This is such a ripe topic, there's just a lot to talk about on the investment side, and this is a great forum in which to talk about it because we do get capital coming together with the providers. I guess a couple things that I'd like to add, [00:39:30] which are different, adding onto what Kelsey's already said. One is that from the lender side, so now we're talking about rather than equity sources but debt sources, one of the big discussions over the last year ... And I think I would encourage all capital sources that are in the lending business to be thinking about the evolution of us as providers to their clients as providers from being real estate businesses to cash flow based businesses. And most of us now have both service lines.

We do have buildings and they can be lent and invested in from a lending [00:40:00] perspective in the traditional real estate lending way and underwritten in that way, but

a lot of our assets and a lot of our cashflow generation now is coming from cashflow based businesses. And so, we're just going through ... And I've got some of our lender partners in the audience here, but going through an extension renegotiation on our multi-bank credit facility, and as we do that there are a lot of discussions revolved around about how to hyperdize, if you will, the facility so it can both lend to us on the basis of our real estate cashflow and real estate assets, [00:40:30] but also on our purely cashflow businesses, that are home health and hospice, that are generating a lot of our cash now. And so, that there's [inaudible 00:40:37] capacity there that we want to tap into to grow. That's very important.

The other thing I would say is that I would encourage ... One of the things that we do is we listen ... As a private company we have the benefit of being able to listen in on our public company peers as they each quarter talk about their strategy and what they're doing, and being at the JP Morgan conference in January where a lot of those companies were speaking about what they're doing. And we listen [00:41:00] to the REITs as well because the REITs are really very close to our industry, and they're of course here and they're lending and their clients and their tenants are in our businesses. And what I hear, and just hearing all those fourth quarter calls right now, so much sophistication on the one hand about what their tenants and clients are doing, but still there is sort of an old fashioned real estate based lending thinking about it.

And they're not yet talking about the advantages in terms of value retention of the assets that [00:41:30] they own and are leasing to their clients, how those assets will retain and have better value if those clients are getting into the cashflow base businesses as well to show up and support and assure good market traction over the long term. And I'm not really hearing that on the quarterly recalls, I'm not hearing the REITs say, "We love the occupancy and we love the fact that our clients and our tenants are in some of the valued based initiatives, which tend to be sort of ACO and bundle payments things", but are they going the next step to ask the question about are their clients really investing and thinking forward [00:42:00] into partnerships that are going to make them solid parts of their community that will last a long time and increase the value for the REIT? And that was something that I'd encourage the investor community to think about.

Jason: Yeah, I would agree. Brian, any thoughts?

Brian: Completely agree with everything that's been said. The only piece of context I'll just add is I think in this sector of the industry, unlike other sectors, the upside overwhelmingly outweighs the downside. I think in other sectors they're more equitable, maybe even more [00:42:30] towards the downside, whereas this one I think is more about the sectors own personal challenge to get out of its myopic view of its historical role, but that's all upside, you don't see a ton of pressure on the downside, at least not at this point where we are today. Unlike the SNF industry where it's more equitable if not a little bit leaning towards the downside pressure. That's the context I would say is ... From a tone perspective it's very opportunistic at this point.

Jason: [00:43:00] Good. You probably already talked about this, Peter, but just your two cents worth on the biggest challenge partnering in this new world order? Where do you see the biggest hurdle?

Peter: I think the biggest hurdle is the financial incentives are really always the lagging piece and they're not keeping up. It does feel like you have to really be pretty forward thinking, risk taking, in terms of being willing to invest money, but also [00:43:30] time and talent and management team attention to initiatives that may not have the immediate payoff. And you have to somehow quantify what you think the payoff will be, and then build the case for doing that because the finances are not really there. And Brian was hitting on that a moment ago.

Jason: Yeah, I think Brian hit on it at the very beginning, right? The financial incentives are all misaligned, especially when we talk about post acute. It's not good, it hasn't been good until recently, although, it still hurts today, it's still [00:44:00] good for referral sources to reduce readmissions. It's not good to necessarily reduce length of stay from a financial perspective.

Peter: And it's even harder right now because you've all seen those margins in the provider community erode with the continuing conversion of Medicare part A to Medicare part C, the lowering of length of stay. We're under attack at all levels on the provider side and so everyone's being very careful with their margins. And so you kind of say, "How can you afford to be forward [00:44:30] investing in something that you're not being paid for yet", but you almost can't resist. A couple years ago, and for many of us still involved with some of that process of just investing in a EMR if you're a SNF provider. There was no money for it, but you had to do it to stay in the game. And some of these other initiatives are like that.

Jason: Good, good, good.

Brian: I would just say ourselves, I mean the reason we get disruptive in healthcare is because we can't do it ourselves. The reason these outside [00:45:00] entities come in and take a piece of our pie and then we all lament that they took a piece of our pie, is because we didn't step up and take it ourselves. Some of the Clay Christensen concepts of you've got to find a way to separate the day to day fires and the running of the business, what I call the blocking and tackling, from the innovation. And truly, that's the biggest challenge is the cultural challenge of innovating out of ourselves while still keeping the eyes [00:45:30] on the day to day. It's an extraordinary challenge across healthcare and one that, quite frankly, we're really, really bad at, which is why it has to come from the equity community and new startups and why you see all that across the board being tremendously successful.

Jason: Good. Kelsey, anything to add to that?

Kelsey: No, I mean I completely agree. I would just kind of ducktail onto Brian's comments of there's two different types of operators, right, there's the ones that are dealing with the water leak in the ceiling [00:46:00] so that they can get the floor cleaned up, and then

there's those who are thinking a little bit more strategically. I think we're seeing even the role of the operator starting to look differently, because the requirements of them are more financial wherewithal, ability to have conversations in the community, more engagement into the community. And so, reaching outside of the four walls of the building or the community of which they manage is becoming increasingly important not just for the traditional sources that we all know exist for a sales cycle, but actually to build and weave the relationships that you need to have sustainability in the community.

Jason: [00:46:30] Good. And I can vouch for that, I mean I operate a very small unit within a very large company that's focused ... I'm focused on innovation, I'm focused on reducing readmissions, reducing at the stay, and that's hurting the company.

Kelsey: Yeah.

Jason: And so, then you got to get the operators buy in in order to really affect change, because there is a short term investment that this industry's going to have to make in order to accomplish all we talk about today. Maybe one last question before we open it up [00:47:00] for questions from the audience. Peter, in your mind, what are the most critical metrics that you can define success in the new value based world?

Peter: Well, on the referral network side we sort of all know now sort of the mantra, what are becoming traditional now of your return to EQ, your length of stay, are you participating in [00:47:30] ACOs and bundle payment industry, all the APMs that you can, are you looking at FIM scores? So those are the traditional things. And one of the things that we've sort of noticed is, yes, you have to pay attention to all those things and they do matter, certainly your CMS five star rating ... We used to complain about how we didn't like it for this reason or that reason, and I think most of us sort of said [inaudible 00:47:51] sort of like, "Let's get to the fact that that is the arbiter right now and you've got to be good at it, so get your five stars up no matter [00:48:00] what." But those are sort of now the traditional things. The things that we're seeing as we watch hospital networks narrow, and that works generally, referral networks narrow, we try to be as intensive as we can with each narrowing, each new announcement of who's in a network. What drove the decisions for that?

And I think we're seeing some unorthodox things or things we didn't expect, some of which are not very high tech at all, but will drive decisions in terms of how we grow in the future. Beyond all those things that I just [00:48:30] mentioned, one of the things that seems to be most important to hospital networks and ACOs is physical location. Hello, I mean it's like the most basic thing, but it really means a lot to hospitals. So if you're thinking about building a facility, do your due diligence and pay an extra \$5 dollars a square foot for the land but park yourself right next to the hospital. It will pay off. And that's sort of a ... It's a simple thing but it's very important.

Physician relationships, those drive referral networks. I mean we just saw recently in the North Texas market, Texas health resources, continuing to [00:49:00] narrow its network and name who are the facilities that they're going to have in their network. It's

very important to them who the physicians are. So are you aligned with the right physicians? Very important. Do you have a historical hospital referral volume? Maybe you've been in nus for 10 years already and you can actually show over the last 5 years the volume of referrals that have come from that hospital to you. Well, lucky you if you are, and use that data to your advantage because that is going to say something to the hospital about, "Wow, we never really noticed that." And it's amazing, but they don't, that [00:49:30] that data is out there and you can actually show then that you have referrals. There is some non-traditional ... I call them non-traditional but some things that we haven't really thought of as obvious before, but the hospitals are certainly on to them and I think they're important to focus on.

Jason: Yeah. One thing I'll add before I open it up, is in this world of ... It started with bundle payment, it's transpired with Medicare shared savings program, but our hospital partners, our physician partners, our orthopedic surgeon partners, they have all of our data, [00:50:00] so the other thing that really makes this a complex area to work in, it's totally transparent now. Again, I wasn't in this part of the industry 10 years ago, but I'm sure you go to the hospital and they say, "What's your readmission rate?", you say, "10 percent." Now they know it's really 17 percent. They've got real claims data. So the light's shining down and it ... I think it's really changed the paradigm of this game.

Brian: I'll flip the perspective a little bit and put on a different hat of [00:50:30] what data and metrics do you need to pay attention to to do the right opportunity analysis for your community and, again, leveraging the lessons from those that came before, like post acute providers, health systems, physicians? You've got to break out of your own revenue cycle mentality and not focus on rent and rent escalations, which is primarily private pay, but instead look at claims data and say, "What are my [00:51:00] residents costing the system and who's paying that bill?"

Jason: And it matters?

Brian: It does matter.

Jason: Because it hasn't mattered before.

Brian: That's right. Is it Medicare, is it the hospital down the street, is it the big physician practice down the street, is it the payer down the street? Who's paying the bill, what's the source of cost? And the good news is there are now inordinate amount of data available from CMS through all of these pilot programs, and so we've got more transparency, more patient identifiable claims [00:51:30] insights than we've ever had before, to follow patients for an entire year of care, if not a five year period of care, so we can see the progression. I think doing that, engaging in that I think would be hugely enlightening for a leadership team of a senior living provider. And you can get that from an ACO in your market, a bundler in your market, you can get it from consultancies that are QEPs with CMS or that have various business intelligence tools. Going through that exercise to understand ... [00:52:00] Because all of your residents are Medicare eligible, or the overwhelming majority of them, so they're costing somebody money somewhere in the system. Doing claims analysis with that mentality I think would lead you to the

metrics that you need to focus on, and enlighten you to perhaps a services model that might provide opportunity for you.

Jason: Okay. Kelsey?

Kelsey: Yeah, I'll just wrap up. I mean, nice throw out of some CMS terminology there, Brian. QEPs, the qualified entities [00:52:30] that get CMS data. It warms my heart to hear those CMS acronyms. But I do think a couple ... Based on their comments is one other thing, which is the increase of Medicare advantage. We now see more and more Medicare advantage plans, new plans, right, like the care more is reinventing themselves time and time again with devoted in North Carolina and others. And so, I think if you can target that level of data and actually go to the payer in your market, that can be a really, really strong place [00:53:00] to start to understand what are the metrics that are important to them base don their presence and their desire to have increased market share over a period of time, which you can obviously help with because of the population that you have access to.

Brian: If they even know their own data.

Kelsey: I mean, come on.

Peter: Well, and one more thing to add, I think, which is sort of hopeful for the smaller providers is in a world of big data, and as we watch narrowing networks from a variety of angles, we're seeing that it's not necessarily if you're a chain, a medium chain or a really big chain, that you as a chain [00:53:30] are being looked at as a whole. Payers and referral sources now look at individual facilities and they want to cherry pick in the market, and why wouldn't you if you can with big data? I think that that's hopeful for even the smallest of providers to say, "There is a chance, you're always at the table." We encourage everybody about being part of the value based world, but really the most important thing is to be good at your bread and butter game, is what Brian was mentioning, is really produce great outcomes at low cost, and you're going to be at the table even if you're only a single [00:54:00] provider. And that's good news and important news for every provider whether you're small, medium or large and for every REIT and capital source to know that your client and your tenant can be in the game. The most important thing is they provide great outcomes at a reasonable to low cost, and when they do they're always going to be there.

Kelsey: Peter, I think that's an excellent point, because oftentimes people want to partner with the big systems as opposed to the little ones, and with the bigger systems just comes more complexity and more decision making process. And so, one [00:54:30] of the things that I've seen some post acute care providers do is actually target the smaller locally owned ones just because decisions get made easier, it's easier to have access to them, there's geographic proximity. Like you mentioned, that's super important in those decisions, but I think that ...

Peter: And the data's there, even if they're not conscious of it. They have to submit it to CMS anyways.

Kelsey: Exactly. Yep, yeah.

Jason: And I'll also end this with a final thought around metrics. Understand what your partner wants from you. They may not care about your [inaudible 00:55:00] rate, [00:55:00] right? They may care about how you track on hemoglobin A1C, they may care about flu vaccine rates. Understand what they want, because you're helping them get people out of the hospital, they're telling you to keep people out of the hospital, physicians are trying to manage down costs, especially as we go into [inaudible 00:55:21], they're going to have different metrics in their head than what the industry is used to projecting. With that I'd [00:55:30] like to open it up to any questions.

Kelsey: One housekeeping item that the room moderator asked is that we use the microphone, because they're recording this apparently.

Jason: Right.

Kelsey: If you have a question, please wait for Debbie.

Jason: Thank you, Kelsey.

Speaker 5: I don't know how many of you have actually been a post acute consumer. I thought I was really smart about this industry until I became a consumer, and it's been horrible and I've talked to people [00:56:00] who haven't. You've talked a lot about networks, the needs of the various organizations, and I think the people who are really getting short changed and who are really confused are the consumers. I went through Medicare advantage with somebody who didn't have a lot of money, they went through their post acute rehab on a hip and once the 14 days was gone it was, "Out of there, we don't care what happens to you." And I've heard so many stories about that. [00:56:30] And I think that really the opportunity that really didn't get talked about is to say, "How do we actually make the consumers like us?" Any thoughts on that?

Kelsey: Yeah, one of the important parts of and advantages of a network is that in theory it's supposed to help seamlessly transition patients through, right? And that's the ultimate goal of building out these relationships and partnerships and service level agreements so that there is a standard in place so that people aren't getting dumped to the curb. I think that's the ultimate desired [00:57:00] outcome of these networks, and we have to wait for some of the payment models to actually catch up to us, which we're seeing slowly.

Peter: I think two things. One, I think we're all patients at the end of the day and we all age, certainly. At the doctor last week and frustrated by everything that happens in that experience, even though my doctor is well meaning. We're all confronting that, a frustration of being the consumer of these services. But I think Kelsey is exactly right, what we're trying to do with the network formation is to share [00:57:30] information in a better way and to orient the way we deliver the care in as efficient and connected way to result in a better patient experience. And we're using tools to measure patient experience, but frankly, in healthcare generally the scores are awful because people

were not that connected, so there's a lot of work to do. But technology is starting to provide us with some of the tools to key in better on what is most important to the consumer and help us focus our intention on fixing that.

Brian: I think a couple [00:58:00] breakdowns. One, consumers go where the system tells them to go almost blindly without questioning it because they're not armed with the information to push back in any way, so whether it's a level of care, particular provider of care, most consumers go where they're told to go either by their physician or someone else in the process, which adds to the dynamic you just described. The other is healthcare is 1,000 fragmented human behaviors from various caregivers, and so I think today where we are in [00:58:30] the state where technology can't solve for all of those shortcomings, you see services models that have care coordinators or care navigators that don't solve all problems, but certainly help from a consumer perspective the experience to be better, the information handoffs to be more seamless, for things not to get lost in the cracks, transitions are smoother. It's an expensive model, I don't know that it's a sustainable model over the long term, but having human [00:59:00] clinically trained person who's following the patient throughout their care trajectory at least Band-Aids the current dynamic that we have in place today. And those services models have been successful.

Peter: Can I add one more thing? I had probably 10 interactions with various post acute and acute care organizations, I don't think I ever had anybody who ever said, "Let's just sit [00:59:30] down and look at your problem, and let me see if I can give you some guidance." That would seem like a really great opportunity for the industry to really build relationships.

Jason: Yeah, I think it actually gets back to... Brian opened up with why the naviHealth's in the world are there. The providers weren't doing it. And providers are waking up and other folks are waking up. And that doesn't necessarily ... With Medicare advantage or [01:00:00] any insurance product's going to have certain things, but when we get this third party involved ... And I'm sorry, guys, and I won't go off too much. But when you get these third parties involved it just creates a different dynamic, and it doesn't allow for what you just said. But that's because the industry hasn't stepped and said, "Let's care about this person. Let's not just keep them in here for 21 days because I need the money, but let's move them along in a practical way. Let's care [01:00:30] about them when they leave. And when they leave, let's make sure they get home health. When they leave, let's make sure they get that physician visit." We need to do that as an industry.

Peter: [inaudible 01:00:40]

Jason: What's that?

Peter: I think there's money for that ...

Brian: Absolutely.

Kelsey: Yeah, absolutely there is.

Brian: There absolutely is, yep. That's the kicker is we weren't paid to do care navigation under fee for service reimbursement. Why did Humana buy Kindred at Home, not because of home health margin potential, because of total cost of care reduction potential [01:01:00] that the Kindred at Home model provides them on their beneficiary base. It's a whole mindset shift that's going on.

Jason: Yeah, I mean you think about the Kindred acquisition for exactly reasons Brian said, you think about Davina Healthcare getting acquired by United. Look at all the moves United made buying physician groups, ambulatory surgery groups, it's because they realized that it's the provider, it's a provider stupid, that's how you make this happen. [01:01:30] And this industry has to wake up and accept accountability and responsibility as a provider.

Speaker 6: We have another question here.

Speaker 7: There's been a lot of conversation about transparency of data metrics and all that good stuff, and totally appropriate, but one of the things that always strikes me is the metrics that we're relying on that are in fact transparent, some of them are remarkably shallow as well. They're not understandable, [01:02:00] you can't replicate them, they're not actionable, they're sometimes not timely, yet this is the data that's being used to form networks, to manage networks, to make very important business decisions. A great example is when you think about the SNF RN, which is a metric that will be used for value based purchasing, nursing homes will lose up to two percent fee for service on this claims based metric, which will be publicly available, which is publicly available. And [01:02:30] the data's old, CMS has come right out and stated that you cannot replicate this yourself because you don't have access to the databases being used for risk adjustment. You got the point. The question is what do you envision as the next generation, like when we come back to this conference a few years from now we'll be talking about transparent data and what else? What will be better? What's the next evolution of what we have to work with [01:03:00] today?

Kelsey: I think part of the challenge with the data conversation in general, and you hit on this, is just the actionability that you can take off of it. Three year claim sets don't really help you if they're three years old and you're just now getting them. I think in the future ... And one of the things that has been really fun to build out at Honor is actually the communication channels of actionable data. We ask all of our clients on five indicators of health, their pain, mood, sleep, appetite, and bowel [01:03:30] movements every time we interact with them. That's actually data that trending over time or even one encounter we can actually take action on and include the social worker and include the skilled nursing facility, whoever we are in partnership with at that point. I think your question is certainly spot on, but we're in the early stage, we're just building this house. The foundation is being set.

And I think being creative about the metrics that we do use can also be super important. Some of the best hospital systems that I [01:04:00] work with on their management of

their post acute care network, it's managed on like Excel files and phone calls, right? And so, I think we're also looking for this very elegant solution that's just going to appear and this dashboard that's going to be miraculous, and it's not that right now, it's phone calls, it's tabbing the things on pieces of paper still. Recognizing that that's where we are I think is an important component to actually get to the conversation that we'll be having in three to five years.

Brian: I love the phrase you used. I think the data [01:04:30] is shallow because that's the only level by which it talks to one another across healthcare today.

Kelsey: Yeah, if it talks.

Brian: I think that is the challenge, is to go deep, the point right, it obviously goes very deep ... And we won't be talking about this next year, sadly. We've got to have common assessment tools across the industry that allow us to go deep and really understand the patient. For example, we measure function differently in the health system setting than we [01:05:00] do it in earth, than we do in SNF, than we do in home health, and they don't talk to one another. And so, we can't go deep because it's fragmented, the data trajectory and insight is fragmented across 90 days or a year as an ACO or bundle or looks at it or are planned. Until we get there some forced uniformity and assessment and common definitions of all of the clinical aspects of a patient. I don't think we go as deep as you would like to see [01:05:30] and I would like to see, so I think today we start with the shallow, which is majority claims based. Which, by the way, five, six, seven years ago we didn't have that, so we're crawling at least before we walk.

Jason: Yeah, I think it's many years. In a bundle payment world and, again, it's expanding, you have a common denominator, that's called DRG. Folks in post acute world can't spell DRG let alone know what it means, but yet they're forced to call the hospital to find out what the DRG is. There [01:06:00] are big differences in lingo, there's big differences in nomenclature within the healthcare delivery system itself. We don't even talk a common language. I think we've got a lot of work before we get any less shallow than what you're referring to. And you know that.

Peter: And I'd like to add one thing, beyond coming to your session tomorrow, Steven, so we can hear more about the future in CMS five star. But I think the one thing that we'll be talking about, and it may sound trite and actually shallow, but it is sort of the [01:06:30] way of the world, is the consumer at the end of the day wants an easy gauge. That's why five star is so important, it's not because of what CMS has done to create it, people like an easy green button or go-to button. "What's the five star? I'm going there." And at some level that is directional in terms of where we need to be focused. It's about likes.

And we're going to be focused maybe in a shallow way but more and more, and hopefully addressing our first question or point, about it really [01:07:00] is at the end of the day about whether our patients, our population, is pleased with eh service they're getting, and we're going to become every more focused on how do we measure that and how do we determine what the patient wants, even though we think the patient doesn't really know any sophisticated medical and though algorithmic driven this and

that, it's really was the patient happy?: Did they have a good experience? And we've got to get better at measuring that, responding and directing our resources and services to that, and forgetting about complicated stuff that isn't really what the consumer wants.

Kelsey: Peter, I think you bring up a really [01:07:30] good point about this intersection of what the patient wants. And we're in the space, and the senior living community at large, where we are a hospitality and a healthcare company. And so, we're getting measured on both of those things, which I think is super unique and we actually have an opportunity to influence that, unlike the ER that gets complaints that the food is cold. Well, okay, that's fine, you're here for the ER. That actually matters in our industry, because that's actually one of the services that we're providing. I do think it is an incredible opportunity to take a more holistic data set that's consistent [01:08:00] to say what is the true experience outside of just the clinical experience or the hospitality, but that combined level.

Jason: I think we've got time for one more question.

Speaker 6: Yes, we have a question from the left side of the room.

Speaker 8: Hi. Your comment about assessments is pretty interesting and timely. Right now HMIS is ongoing, which is a health information management society meeting, and ONC, I'm getting letters from them a couple, three times day. The really cool part is that there is a movement to [01:08:30] create a longitudinal record to drop things into one bucket, however, lack of the ability to have that structure and data match has been a challenge. My questions is ... What's fascinating to me, and I've had conversations with CMS over the last three years, the impact that the value and the opportunity is to have that standardized assessment to repurpose data elements that crosses over care settings or wherever that person centric record is going to [01:09:00] be. What are your thoughts on that?

Brian: It's incredibly complex. I mean, we've been talking about the impact for what like, forever?

Kelsey: Four years, five years now.

Brian: Yeah, four years now. We were a pilot site moons ago for the care tool, which was one of the first out of the gate attempts to standardize clinical assessments over settings of care. And as a national pilot site what we found is it was incredibly cumbersome, very long, and it was duplicative to all the things [01:09:30] we had to do to generate CMS's revenue cycle today. And so, I think the operational complexities have been underappreciated, and as they've dug into them, that's why you see it moving so slowly. Instead, we've got NQF measures being added here and there and intended to talk to one another, and the reality of if they do or not we could debate. But I think that's hard because you're, not to use a metaphor, but you're trying to change the tire on a NASCAR [01:10:00] as it's running the Daytona 500, and that's really tough to do because all these assessments drive payment today and all these silos. You have a better view on the CMS side than I do. My personal vent is that we're a long way away from a full

system that talks to one another across settings of care that link clinical needs and resources with payment, and that's all very transparent and goes as deep as Steven wants it to [01:10:30] in all of the research angles, patient acuity angles that are important to fully appreciate ...

Kelsey: Yeah, and I think the intent of it is really admirable and I think it's directionally correct, but as Brian said, it comes down to how does it actually impact the providers who still need to submit claims, get paid on those claims, and then also, by the way, fill out this 24 page evaluation form. That's not going to work. We have a long way to go, like Brian said, but I think directionally it's the right way.

Jason: [01:11:00] Okay, are there any other questions?

Brian: Unified pack system may push us there a little bit. If we want I'll throw that one out.

Jason: She's coming, she's coming.

Kelsey: Brian doesn't need a microphone.

Speaker 9: The shift from skilled nursing to home health and being in a network or not being in a network and the comparison, is anybody tracking the amount of readmissions and total cost of care for the population that used to go to SNF and now goes home? And how is that all working, because I've never seen any [01:11:30] data. That's one. The second question is, is anybody tracking patients that do go to SNF that then go from SNF to home health, what that total cost of care is comparison to a longer length of stay at a SNF?

Kelsey: I mean, naviHealth tracks that every single day. That's how we made a profitable business was by managing it and tracking it and having interventions, but humans to do those interventions. I'm not as close to their data sets, I haven't been at naviHealth for two and a half years, but, Brian, you were there more recently, I don't know if you have a different perspective on that.

Brian: Yeah. At [01:12:00] naviHealth I will just tell you SNF utilization went down across all bundles pretty significantly, relatedly SNF length of stay went down in some cases 30-plus percent. Home health utilization went up in every bundle, and readmissions came down. That's across all clinical conditions, all 60-plus hospitals that we were managing. So it is possible and they are a proof of concept that you can manage all of those metrics to a favorable outcome. [01:12:30] And just to further put an explanation point, CMS monitors this so there are BPCI evaluation reports that look at that within the model three structure. I think they've had some challenges controlling for clinical acuity shifts, which they've been very transparent about in this latest BPCI advanced announcement, but generally they also monitor those metrics and the unintended consequences aren't what you might have thought going in. It is possible to pull [01:13:00] the metrics all simultaneously in a positive direction.

Peter: One consequence of that, and I know, Brian, you probably have a sense of this, is that for providers that have tried to be forward thinking and have that extension of services out into the community, in another example of sort of the financial incentive not being there perhaps, we're not giving credit yet. But you go to a hospital system, you go to an ACO or any payer provider, an MCO, and you'd think that you'd get some [01:13:30] credit or some at least acknowledgement that, "Wow, you've got a pretty seamless thing going, your outcomes look like they're pretty good, you're monitoring patients across settings." You go to a conference and everyone says they're interested in that, but you go to a negotiating table and ...

Kelsey: No way.

Peter: "It's like we don't really care ...

Jason: It's clouded.

Peter: ... If your SNFs five star or not, and that's what we care about, and we look separately at your home health. The fact that you're connected doesn't really enter into the equation." I don't know where that comes from, but I have to ... My gut is that at some point somebody will wake up and say, "Providers that are really doing a good job of managing across their own networks are worth [01:14:00] having deep relationships with." But I can't come to you yet and say that I'm seeing that.

Jason: Yeah, agreed. Okay, well I think we're out of time. I want to thank our esteem panel this year, and thank you all for sticking in with us today. Good job.

Peter: Yeah, great job.

Kelsey: Good job, guys.