Planning for the Care Needs of the Forgotten Middle

Beth Mace:

Hello everyone. My name is Beth Mace. I'm the chief economist at NIC and I welcome you to today's session on Planning for the Care Needs of the Forgotten Middle. You're all looking at and I wish I could have a picture of all your faces. You're like, "What's going on here? This is not a normal format." This is a town hall format. We did it last year. We're going to try it again this year. How it's going to work is I'm going to speak for just a few minutes, and then each of the panelists will speak for about five minutes. Then while they're all speaking, we'll all sit down and then we're all going to stand up like this and move around the stage a little bit. That's where we're going to really turn it into the town hall format. That's meant to be a conversation. We want this to be a lot of feedback back and forth, and we're hoping that this format facilitates that.

Beth Mace:

I'm really excited to be here today. This is the third or fourth time that we've been able to talk about the middle market or what NIC calls the forgotten middle, and I'll explain why we're calling it the forgotten middle in a little while. At prior NIC conferences and at prior NIC events, we've talked about the forgotten middle, but we talked about it more from the real estate point of view. So today we're going to really talk about it from how can we in a cost-effective way deliver the care and the services that are required to service seniors, especially middle-income seniors. I have this amazing panel to talk about that, on how we can cost-effectively deliver care for middle-market or the forgotten middle seniors. So I'll let each panelist start to introduce themselves. Starting on my far left, Caroline.

Caroline Pearson:

Yeah, I'm Caroline Pearson. I'm a Senior Vice President at NORC at the University of Chicago. Prior to joining NORC, I spent 14 years at Avalere Health, which is a healthcare consulting firm in DC, so I, if you were in the lunch session, come from the healthcare side of the great abyss, so if you can picture the divide and I hope to step over the divide during our session.

Diane Burfeindt:

So I'm Diane Burfeindt. I'm Vice President of Population Health for Presbyterian Senior Living. We're located primarily in Pennsylvania. We are a provider. We do a lot of rental housing as well as 13 continuing care retirement communities.

Jan V. Eyer:

Hi. I'm Jan Eyer. I'm the Regional President for Complex Care Management for Optum which is a division of UnitedHealthcare. So we provide services to many of the, the middle seniors, the forgotten middle seniors.

Beth Mace:

Great.

Kevin O'Neil:

Good afternoon. I'm Kevin O'Neil. I'm the Chief Medical Officer for Affinity Living Group. I am a geriatrician. We are actively positioning ourselves to become valued partners to managed care organizations, accountable care organizations as a senior living provider. I previously was Chief Medical Officer at Brookdale for about 10 years and then with Ascension Senior Living for a couple of years.

James Lydiard:

I'm Jim Lydiard. I'm a Staff VP at CareMore Health, Anthem Health and we support around a thousand different long-term care communities across 12 different markets and states. Like Jan many of those seniors that find themselves living in residencies and often known as the forgotten middles. So happy to be here and contribute.

Beth Mace:

That's great. So now the panel you can sit down. I'm just going to give you a little bit of background about the middle market. So as I said this is the continuation of a discussion that NIC's been having for a few years now and it's really exciting to in today's conference to really talk about the care component of taking care of seniors in the middle. So let me give a little background though on the study called the forgotten middle and it's forgotten because it's not really been paid attention to from either the private side or really from the public side. If you look at the housing and care needs for seniors the top portion of the housing is really covered by today's senior housing. So a lot of the housing that people can afford today. The bottom portion of the income strata is really covered by some types of Medicaid programs or other types of subsidies. But it turns out there's this huge group in the middle that can't really afford today's senior housing product for at least a very long period of time and they have too many assets to really qualify for Medicaid or other types of programs.

Beth Mace:

We estimate in the year 2029 that there'll be about 14 million of this cohort of middle-income seniors and Caroline who worked on the study she's from NORC at the University of Chicago. She was a lead author of the study that we did so she's going to give you more details in a minute about really what the characteristics are of that group. In terms of the demographic characteristics, in terms of what they can afford turns out that about 54% cannot afford today's seniors housing product. Then in terms of what does that mean in terms of their care needs. So this is the first study that we know of that's actually quantified the number of seniors that will be middle income in the year 2029, looked at what their demographic characteristics are and then layered on top of that what their care needs are. So it's a really great, comprehensive study to give us a sense of what we as an industry really need to be aiming towards to serve this population cohort.

Beth Mace:

The discussions that we've been having are really trying to start a conversation about what it is and how we can actually help this cohort. My goal here really is to excite all of you to want to go out and help figure out the solution to try to provide middle housing options for... Middle-income senior housing options. And if nothing else happens and we're able to excite you a little bit about to start thinking about it and brainstorming about it we'll be really excited. You need to think about it from the capital stack what type of debt will be interested in providing housing to this group? What are the equity sources for it from a design point of view? Is it the same design that we have today? Should it be different? What about the resident experience? Then most importantly what we're going to talk about here what about the care component of it?

Beth Mace:

This is also a study that was published in Health Affairs and if anybody's interested in it, I happen to have one right here. This was the fifth most-read article in 2019 in Health Affairs which is an amazing statement to make because it's called Health Affairs. It's not called seniors housing. It's not called

housing. It's Health Affairs. So that housing was able to be significant enough to garner that amount of attention really shows that the silos are starting to be dismantled. And when I say silos I'm talking about the fact that traditionally there has been people who've cared about health or there has been people who've cared about housing but not necessarily the same. What our study really shows is that we have to come up collectively as a society with a solution that's going to allow people to age as long as they can in the least expensive form and the least expensive housing option but as healthy as they can. So we know that this group is going to have limited financial resources. So what can we do to allow that group to be able to sustain themselves financially for as long as they can while staying healthy?

Beth Mace:

So we're trying to break the two silos and merge them into one discussion. You've seen a lot of theme of that at this conference and in this specific session, we're going to be talking about that as it relates to the middle market. So when we've looked at this study there are a few challenges, significant challenges to address this. One is the equity side, the equity contribution of the capital stack. Is it going to be pension funds? Institutional funds? Is it going to be high net worth individuals? Who's going to provide the equity side?

Beth Mace:

The debt, if there's bankers in this room and if I ask you to raise your hand, every banker would be interested in trying to provide debt into this cohort or into this opportunity. We also have regulatory challenges that come along with this serving the middle market and doing it at a scalable level. Then the fact that we have increasingly complex needs of residents and how do we manage that? So our focus as I said today is going to be on the complex needs of the middle-income residents as well as the cost of care. With that, I'm going to ask Caroline to come up. So maybe give a little background on what you did on the study?

Caroline Pearson:

Thanks, Beth. Yeah. So NORC partnered with NIC to really try to quantify the size of this forgotten middle population and when we set out to do the work we were not just trying to look at what is the middle class. It wasn't sort of a traditional middle-class definition. As Beth said the definition of the population that we were looking at was really driven by their access and affordability of existing senior care options in the market today. So on the one hand, on the one side of the spectrum, we have the lower-income individuals. This is where our safety net system within the government programs comes into play. Folks who are very low income get covered on Medicaid for long-term care services. Those who have very acute, serious long term care needs in skilled nursing facilities.

Caroline Pearson:

On the high end of the income spectrum are all of the folks and customers that you guys know well today. People who can really afford private pay senior's housing options and as they're thinking about aging and where they're going to live they've got lots of choices. They may be able to stay in their home and pay for in-home support and at some point, they may decide to move into assisted or independent living facilities. The folks that we were really trying to target were those in the middle. Those who by definition of not being in one of those other two buckets have fewer options available to them in terms of the housing and care that they can access. These folks generally rely on the unpaid support of family and friends in order to provide any sort of assistance that they might need when living in their homes. Sadly, if their healthcare needs become bad enough ultimately they spin down to Medicaid.

Caroline Pearson:

That is actually the plan in the system today is you hang out here as long as you can and if you can't you spin down to Medicaid. So we wanted to really understand who are these people because as the baby boomers age we envision that that group was going to get a lot bigger and we needed to know how to address their needs. Just to give you a sense of the financials here we honed in on the cohort who's the 41st to 80th percentile of income ranging from about $25,000 a year up to $95,000 a year for the oldest folks. This is income as well as annuitized assets from retirement savings and otherwise. But in general, we're looking at people with a mean annual financial resources of about $44,000 a year.

Caroline Pearson:

I think the striking thing to most people when we shared these study results was the sheer growth that's going to happen in this population. Everyone knows there's a lot of baby boomers but when you begin to look at the numbers we're going to see 82% growth from a middle-income senior group and here a senior is 75 and above. Of about 7.9 million today up to 14.4 million in just 10 years. This represents just the first half of the baby boomers. So there's more behind them and as I said we don't have great options for them today.

Caroline Pearson:

We'll come back to that slide. Who are these folks? How are they different from people you may be serving today and how are they different from the middle income of the present? What are their needs going to be? We're going to see a big increase in racial and ethnic minorities. A much more diverse population over time. Interestingly we see a big increase in education. This is a group that grew up in the era of requirements for people to go to school. Requirements for high school attendance and so we actually see improvements in education status but notably decreases in marriage rates. As we begin to think about those unpaid, informal sources of care that people rely on, fewer of the baby boomers are going to have spouses at home with them to take care of them as they age. Fewer of them will have children living nearby who may be able to provide supportive care to them.

Caroline Pearson:

Maybe these guys are all healthy. Maybe they're okay. Maybe they don't have needs. What we saw is in fact 8% of this population has cognitive impairments or is projected to have cognitive impairments. 60% of them have mobility limitations and 20% of them are high needs meaning they have a combination of three or more chronic conditions and one functional impairment. What you all know as well as I do is it is these attributes that are generally what cause people to no longer be able to live independently, no longer be able to stay in their home and need other more supportive housing options.

Caroline Pearson:

So just to give you a little more detailed look at that. Here are some of the specifics so interestingly because this is the first half of the baby boomers most of the growth in the population is in the 75 to 84 but if you look at the rates of these conditions they increase a lot more after age 85. So we're going to see the first wave of it over the next 10 years but those baby boomers 10 years from now are going to be starting the physical and mental declines that are really going to need more attention. It was really interesting as we released the study to see how much reaction we got. I think the putting numbers to the problem gave people a sense of just the magnitude of the unsolved forgotten middle challenge and so hoping to hear more about solutions today.

Beth Mace:

Great. Thank you. Importantly, as you pointed out Caroline, this study only went out to 2029. That's just the beginning of the baby boomers entering into this 83 and older cohort so that's when the needs are really going to get significant. So the 14.4 million that we're talking about is only going to exponentially grow. Next up I'd like to bring up Diane. And Diane your title is Vice President of Population Health for Presbyterian Seniors Living. What does that mean? Our audience probably doesn't even know what that means. Can you help us understand that a little bit more?

Diane Burfeindt:

Absolutely. So my role at Presbyterian Senior Living Vice President of Population Health, first of all, I'm not a clinician. So that tells you right off the bat a little bit about what I do and don't do. I think especially after listening to Andy just in the session right before this. I think a lot of what I do overtime is really looking at ways to breakdown these silos that we all have and in looking at things in a very non-traditional way. So I got my start in this work before all of these things were in vogue. My background is in hospital work, hospital administration and I've been with Presbyterian Senior Living for 22 years as an operator for much of that time. But where we really got our start was in a very easy, simple way where we had and I should say that we have about 26 rental housing sites as well as 12 or 13 CCRCs spread throughout a four-state region. So we have a pretty good diversity but where we are in Pennsylvania we're squarely in the middle market all the time. So we're really not a lot in the big cities, we're in a lot of the rural areas in between and even in these settings they are primarily the middle market.

Diane Burfeindt:

So this becomes really obvious to us before we even coin some of these terms it became really obvious to us that there were some really big gaps. As Caroline was just saying there are lots of services for individuals that are dual-eligible and on Medicaid. But when you really start to look at what happens in the middle there really is a lack of coordination and services for these individuals. So we got a start in one of our markets. We don't have a lot of density in any given market. We have pretty good scale throughout Pennsylvania but we got started just on a very personal level with a hospital system who noticed and again data I think is a theme that we're going to hear throughout this conference. They noticed in their data that they had people that kept going to their emergency department and leaving because they didn't like the length of the line.

Diane Burfeindt:

And guess what those people happened to be in our building because they were able to look at the address. So we got together and we said, "Okay. Well, we know this isn't good for our residents." We're a non-profit and for us, we really care about care and about treating patients well and really trying to improve the care. We have a 90 plus year history of this so care for us is just a part of what we do. But we looked at it and said, "Okay. So what's going on here? Why did these people walk to the emergency department?" And all of these things now years later become a little bit more obvious. These were all issues of social determinants of health before that term was even well known. So we got together and we said, "How are we going to help solve this issue?" And of course, what was happening is that individuals were using the emergency department as their primary care and what we really found is that there was some significant gaps in what was happening to them.

Diane Burfeindt:

So I think this morning, this was a slide that was used that I think really explains this well. Where so much of healthcare is not in that little red healthcare space but is in everything else that happens around it. I would say that most of my work hovers above all of this. So it's great to say that we might want to try to impact behavioral home and family stress management but what you really find in a lot of these settings it's the coordination. Again that's not a surprise if you've been in the care field for a while. So what we've been trying to do, what we started doing back then was to really look at reducing readmissions but again we were doing this in a very non-traditional setting so we had a hospital system that was interested in, are there patients not just using the ER for primary care?

Diane Burfeindt:

We had a desire to help treat our residents better and have them not have to have mismanaged care. So they ended up putting a clinic on-site and I think the lesson learned from all of that is it took us a lot of time sitting down at the same table, figuring out the language issues that we had and how we were going to solve this problem together. Because they would say things like, "Well, can't you just make all of your residents do this?" "Well, guess what. No." We have no control over them much like nobody has any control over all of you. And I think that's where you get into some of that individual behavior. So we really had to sit down and talk about what it is that you're trying to accomplish, what are we trying to accomplish and how can we work within this system for mutual benefit.

Diane Burfeindt:

So that's what I spend the majority of my time doing. That has evolved over time from working on the front of rental housing to suddenly of course skilled nursing became very important. So with our scale that we have in Pennsylvania, we were easily able to take what we created in rental housing with a hospital and say, "Hey. Look if we can do this in this really difficult place imagine what we can do in a place where we actually have some more control." So that's really how we got our start and I think to Andy's point in the last session. I believe part of my role now is really to design new systems as well going forward. Again really taking a look at who has control of the dollar and where scale matters especially for those individuals that are in our settings.

Diane Burfeindt:

It's taking a look at how those payment systems work together and trying to find different ways. But I think at the bottom of it all is really spending the time to sit down, talk about it, what you're trying to accomplish and understand the limitations that each of you is coming at this with and finding different ways of getting past those. Because so many times a conversation will start, "Well, we need this information." And we say, "Well, we can't do that but what is it exactly we're trying to get to and let's find a way to do that. So that's been really successful I think for us.

Beth Mace:

So Diane, stay with me for one minute. How do you see Presbyterian Senior Living developing a product that can specifically serve the middle market?

Diane Burfeindt:

So one of the most important things I think in this conversation is what's happening in your individual markets. I work primarily in Pennsylvania and that is one of the red states here where... Red in maybe a couple of ways. One of the red sates here where we're at 41% Medicare Advantage penetration. So 41% of people are on a managed care product in Pennsylvania. That is one of the fifth highest in the

nation and we've been there for quite a long time. That dramatically changes how we act and if you were in the western part of our state in Pittsburgh that number would be almost 70%. So we have a lot of... And by the way in Pennsylvania, we have a lot of regional players. We do not have the Kindreds and the Humanas. We have the UPMCs, the Geisingers, and the Highmarks.

Diane Burfeindt:

So in terms of the products that we can bring to the table when we sit down with them and we look at what are the things that they get measured on the HEDIS measures and the HCC scores. There's a lot of things that they don't do well and there's a lot of things we don't do well. So we take a look at that information and say, "Okay. Where are the areas you're having difficulty with?" Well, guess what. One of the things that they happen to have a problem with is getting people to their annual wellness check-up with their doctor. Well, heck, that's something in senior housing we could do really easily. They also have issues with people adhering to certain care plans and things of that nature. Well, again when we look at the fact that people live with us and we have a tremendous amount of trust with them they will trust us and will do things that a managed care provider can't get them to do because they don't have that kind of relationship. So I think ultimately what we're looking to do is to really figure out ways in which we can leverage that trust and that expertise that we have in that relationship with our residents to bring new things to the table particularly with managed care because that is so pervasive in Pennsylvania.

Beth Mace:

All right. Thank you.

Diane Burfeindt:

You're welcome.

Beth Mace:

Jan, you're up. All right. So Jan you work for Optum and it's a really large diversified company. What current relationship exists between Optum and the seniors housing sector? And then how does that apply to middle market?

Jan V. Eyer:

Yeah. So senior housing I work in complex care management as you know Optum is a really big company. Main Line Health itself is 350,000 employees so if you can imagine. But UnitedHealthcare is the insurance vehicle and the division I work with is the care model. So we provide nurse practitioners in nursing homes, assisted living and independent living. In 2003, Medicare came up with special needs plans. There are three different kinds of special needs plans. There's a dual SNP plan are those who are both Medicare and Medicaid eligible. There's a C-SNP plan so there are about 15 different buckets that they put people may have heart disease or dementia issues or diabetes and they have care models that will follow them. Then they have an institutional special needs plan and what expands that further is the institutionally equivalent special needs plan. So you can be in assisted living, you can be in independent living and still qualify for one of these Medicare Advantage plans.

Jan V. Eyer:

As Diane spoke, the increase of Medicare Advantage Plans is huge. I'm the Western President for CCM. So is you see Colorado, Washington, Arizona, Utah. Very heavily we have a lot of Medicare Advantage

people. So if you can have those people and you can send a nurse practitioner and you partner with the facility to manage their care. So you can look at social determinants of health. Do they need... Medicare has expanded the definition of what those additional benefits can be so glasses, dentures, hearing aids, foot care. That's all pretty common but now Medicare is allowing you to provide meals in some cases. So you can have someone's gone to the hospital there's food and security issues that we can now send food home with them. Medicare will also provide under these Medicare Advantage Plans activities of daily living. So help with bathing, that piece.

Jan V. Eyer:

So some of the things that people in the middle market couldn't afford they can afford under a Medicare Advantage Plan. Let me see if I can figure out... Aha! There we go. So the principles of the model of care that we provide is that we deliver the care onsite and we partner with those kinds of facilities. So long-term care, assisted living, independent living. We have the nurse practitioner onsite or it could be a physician assistant or an RN who works very intimately with the primary care provider. So that we can look at providing their preventative measures if they need to have colonoscopies we need to make sure they have that. Their mammograms. We need to make sure that they're taking their blood pressure meds. We can measure all of that and we can communicate with the facility if that's appropriate or we can also communicate with families if they allow us to do that.

Jan V. Eyer:

Because many people in Colorado, this may be true all over, but that's my home base. Their families don't live there. Their families may be back East, they may be in the Midwest and they need somebody who can keep up with those individuals particularly. Then I'm going to move on here. I don't know that I'm going to go over this a lot. It's really what happens in providing a Medicare Advantage Plan and the things that the nurse practitioners do and the physician's assistants do. Medicare reimburses you as a system for being able to identify the diagnoses that somebody has. They reimburse you because you meet certain star measures. So star measures are that you make sure somebody's had their mammogram when it's appropriate within certain parameters. So you make sure that they're taking their blood pressure medications that you worry about all of those social determinants of health and their outcomes and the preventative medicine part of it.

Jan V. Eyer:

I'm going to go to one more because one of the things that we talked about as a panel was the interest in how senior housing can participate potentially in Medicare Advantage Plans. So two years ago Optum started doing... It's a little off the slide. Optum started consulting with senior housing providers to say you're starting your own Medicare Advantage Plan and how might we provide resources for you to do that? So first of all if any of you are thinking about starting your own Medicare Advantage Plan just beware that you take risk so that you're responsible for that member going to the hospital. You're responsible for their therapy costs. You're responsible for their dialysis. You're responsible for their home health. If one of your members happens to have a stroke you're responsible for all of that care.

Jan V. Eyer:

Now there is reinsurance if you have somebody who has to have a kidney transplant but you have to really understand managing all of those expenses and what's that mean. We do have members who are not or partners who are not part of UnitedHealthcare who want to do that. So I made a list of all the things that you needed to consider if you wanted to start your own Medicare Advantage Plan. As you

can see it's pretty extensive. I'm not going to go through it. I'll go through it if people ask more questions.

Beth Mace:

[inaudible 00:28:28].

Jan V. Eyer:

Yeah. And I keep talking.

Beth Mace:

We'll have time for questions in a minute. Thank you.

Jan V. Eyer:

Okay. Mm-hmm (affirmative).

Beth Mace:

Kevin, come on up. So Kevin your work for Affinity Living Group which is one of the largest senior housing providers in the Southeast and you have a title of CMO which is not Chief marketing Officer but Chief Medical Officer-

Kevin O'Neil:

I've been accused of that though.

Beth Mace:

The Chief Medical Officer. So what is your role as Chief Medical Officer? And you were in that same position when you were at Brookdale too so how has that changed over time?

Kevin O'Neil:

Well, I can tell you. I'm really excited to be here because 15 years ago when I first realized that we're going to be making the transition from fee for service medicine to value-based care I said, "This is an extraordinary opportunity for senior living providers." But at the time I felt like I was a voice crying in the wilderness. That no one really understood it and as a geriatrician, I can tell you that I thought that was the bane of good geriatric care was fee for service. And why is that? What does fee for service pay for?

Kevin O'Neil:

Volume! More tests, more procedures, more interventions many of which are inappropriate in our population. So I was really excited to see that over time we were going to start paying for outcomes, getting good outcomes, doing the right thing for the right reason. That's why I've been really excited to see the increase in managed care organizations, accountable care organizations delivering care based on value and based on outcomes. So my role is really in charge of all the clinical programming. We're engaged in a lot of research related to these types of activities. We've had active conversations with Optum and managed care organizations and ACOs. We plan on taking risk in the not too distant future but we're going to do it with a partner because we know we can lose our shirts if we don't do it right.

Beth Mace:

[inaudible 00:30:11]specifically for the middle market?

Kevin O'Neil:

For the middle market-

Beth Mace:

Are there special interventions for that group or-

Kevin O'Neil:

Yeah. Absolutely. And I think that's why I want to talk a bit about the integrated care model because it's going to be really important to understand that folks that are in the upper echelons in terms of socio-economics generally have had good health behaviors. They've taken care of themselves. When we talk about those social determinants. So a wellness program is appropriate for them but those in the middle markets where they may have had health behaviors whether it's cigarette smoking, obesity, those social determinants and those health behaviors that may have impacted them they're going to need more aggressive management. I'm going to talk in my presentation about the geriatric 5Ms.

Beth Mace:

Okay. Let's see if I can find them for you.

Kevin O'Neil:

Okay. I love this quote. This was from Karen DeSalvo when she was acting assistant secretary for HHS and she says, "There's more to the health system. We have to be investing in housing and food and transportation, just as we are in things like quality." As you've heard before what we do with the doctor's maybe about 20% of health. The other outcomes: socio and economic factors, the health behaviors, environmental factors play a significant role but senior living providers address a lot of those needs don't they?

Kevin O'Neil:

I mean you look at this they provide food, regular meals, access to care. More and more of senior living providers are making sure that on-site services are available. Transportation and an environment of safety, quality of safety in most senior living providers. But many of our residents and I think you know this have significant challenges. The average older adult has three to five chronic conditions, five to 10 medications and that's probably conservative. As I toured around and visited many senior living communities to see the number of medications that folks are on are just extraordinary.

Kevin O'Neil:

So we as geriatricians are focusing on what we call the geriatric 5Ms, which stands for: mobility, mind or mentation, medications, matters most, and multi-complexity. When it comes to mobility issues we know that you've heard about the obesity epidemic. 68% of the American public by 2019 overweight, significant mobility problems. I was at Disneyworld a week ago with my wife and my grandchildren and to see the number of people running around on scooters, I just couldn't believe it. But also the incidence of neuro-muscular diseases, neurological diseases that impact mobility. Parkinson's and peripheral nerve issues that need to be addressed. Do you know how many people over the age of 65 fall each year?
Anyone know?

Kevin O'Neil:

One out of three. Age group over 80, one out of two. And of those who fall a significant percentage probably 20% or more are going to have a significant problem. A hip fracture, a spine injury, head injury. Significant public health problem that we as senior living providers can help address. Mind mentation, maintaining mental activity. The prevalence of Alzheimer's disease doubles every five years after age 65. It's one to 2% at 65, two to 4% at 70, four to 8% at 75, by the time we get to 90 its 50% or more. So we're going to be addressing this more and more as people live longer. Mental health disorders, depression. 20% of women are going to have major depressive episode during their lifetime, 10% of men. So we need to be aware of these things and cognizant. We need to have ways of addressing and evaluating.

Kevin O'Neil:

Medications. I'm shocked when I go and see how many pills people are on. They're like chemistry sets. Massive amounts of drugs. Many drugs that are inappropriate, seldom appropriate. In geriatrics, less is more. Critically thinking about drugs, we often see with these prescribing cascades, someone gets put on a drug, they get a side effect, they get put on another drug to manage the side effects. So now there's a big focus on de-prescribing. Getting people off inappropriate drugs. Some of you may have heard about the Beers list. Mark Beers was a geriatrician, brilliant fellow and he actually developed a whole list of drugs that are inappropriate in our population. I'm sure you've seen many of your residents on them, anticholinergic drugs that augment cognitive impairment. Anti-psychotics that are over abused. The Government Accountability Office just a few years ago in 2015 specifically cited assisted living providers for the overuse of anti-psychotics. Skilled nursing providers have been doing better but these drugs are being used off label for managing behavioral symptoms and dementia have significant adverse impacts in terms of stroke risk, myocardial infarctions, and death. So we need to be really aggressive about this.

Kevin O'Neil:

Multi-complexity. As we said before three to five chronic conditions. 5% of Medicare beneficiaries that are consuming 50% of the Medicare resources. Those with four or more chronic conditions count for 90% of Medicare spending. So we need to help manage the goals of care, work with our residents, what are their goals for their care, understand that advanced care planning has an appropriate role. One of the basic tenants of geriatrics is the hospital is a dangerous place to be. The incidents of delirium, hospital-acquired infections. The hospital should be the downstream provider for us. You heard before at the lunch-time presentation many of these conditions could be managed appropriately onsite with better recognition of changes in condition and earlier interventions.

Kevin O'Neil:

This is the traditional model of what's happened. A senior has multiple conditions, multiple doctors. Probably little home support. They have a change in condition. They end up in the ER. The ER became the hub of the enterprise, the triage area. The ER doctors know who they are, the system's become so fragmented because now we have instead of the primary care doctor going monitoring their patient in the hospital. We have hospitalists, we now have SNFists, inaudible 00:36:08] we got a whole fragmentation of the system and little communication, important information falling through the cracks. You can see the litany of what happens. They end up going to post-acute long term care and we go through this cycle again.

Kevin O'Neil:

So creating an integrated care model, it doesn't mean that senior living providers need to be providing that service themselves but be the convener. What we're doing in our communities was we're convening onsite healthcare providers to work with us, collaborate with us. Onsite home, health, and therapy service. I'm delighted that more and more senior living providers are doing this. Important areas to focus on. Med-optimization as we said before, falls. How do we prevent and reduce falls, transitions, advanced care planning? Transitions of care. Become a valued partner to the managed care organizations, the accountable care organizations, your hospital systems because if I was a CMO of a hospital or an MCO I'd be looking out right now, who are those providers out there that can help me address the needs of this population?

Kevin O'Neil:

I can tell you I would not be using a provider who's automatically, reflexively sending everyone to the ER. So it's really important. In my other slides kind of give a way that you can approach this in the future in terms of building that model and addressing those needs.

Beth Mace:

So Affinity does a lot of middle-market so you're walking the walk and talking the talk.

Kevin O'Neil:

Oh, yeah. Absolutely. Yeah. We're trying to address both the middle and lower-income strata as well. So we're trying to address both needs. Yeah.

Beth Mace:

Thank you.

Kevin O'Neil:

Thank you.

Beth Mace:

Jim. So CareMore has made a lot of headlines in the seniors housing industry last year. You're doing a lot of work right now with Welltower can you tell us a little bit about that? Then more recently Welltower's announced a plan to do more "affordable" seniors housing and is CareMore involved with that?

James Lydiard:

Absolutely. Thanks. I'll come back to that slide just to answer this one. So with Welltower and their partnered operators, we set up some time with them about a year ago and really sat down and started to look at certain goals. A big theme and I think yesterday and certainly, today is if you're going to find partnerships if you're going to work with others you got to mutually align on goals. You got to speak the same language. So we were looking for these altruistic opportunities where we could be a care solution to some of their settings, some of the same settings that they will review with their operators and pull out sore spots. What we came up with were small, few, simple actionable goals that we've put into action. I should preface by saying that our relationship with Welltower is not financed.

James Lydiard:

There's no dollars that we're exchanging with them today. They believe in us and we believe in them and we believe we have something to offer them. The goals that we looked at were decreasing polypharmacy. So our statistics show that over about 7,000 IE-SNP Medicare Advantage members that we bring aboard come aboard to our service at about 12 Part D drugs per member per month. That sound right? [inaudible 00:39:23] Yeah. Part D I don't want to get into the... over the counters, too. Within six months our population is at less than six and that's actually something that we include in our CMS model of care.

James Lydiard:

The second thing we looked at was decreasing admissions to the hospital. So inpatient avoidance. There's some great published data even just out this week from ATI around assisted living and long term care, hospitalization rates, ER rates. To say the least that having models like Optums and CareMores in your long term care community can decrease that dramatically, increase the access of care. If you do so as a skilled nursing facility, of course, you're able to keep those patients in their setting appropriately, move them to a skilled bed appropriately. Keep all those daily costs and daily rate opportunities in house. And if you're an assisted living community you know that probably the greatest reason that people move out and need a higher level of care is they go to the hospital and they don't come back home.

James Lydiard:

So you keep the patient in the bed. You keep the patient at home. You do right care, right time. You can obviously increase that. We're looking at member engagement. So how can we ensure that we're making these services aware to all the eligibility that live in the house essentially and if we do all those things and do all those things well we increase the assisted living average length of stay? We increase the aging in place. What we found in our studies and we've worked with a couple operators now for about 10 years in which to study this is our average length of stay for one nameless operator I'll just use. This is 31 communities over four states. We support about 500 of their residents in assisted living memory care. Their average length of stay in those same states is 22 months. Their average length of stay in those same states, in those same communities with CareMore almost 40 months.

James Lydiard:

So these are real-time data, real-time pieces that Welltower and CareMore are partnering together to further prove out and hopefully we're finding the value prop. It’s that triple aim buzzword. It works for the Medicare Advantage organization, it works for the long-term care community and it certainly works for the member. Welltower living is another very popular topic in the news these days too. So just to keep going with this slide. Welltower living is going to be ideally I believe their solution on the middle. We are not affiliated with that opportunity with them at this point but certainly, we're seeing markets where our coverage and capabilities overlaps with theirs and we would love to do something with them. I think that we have a lot of ways in which with multiple Medicare Advantage offerings, not just IE-SNPs but special needs plans of the chronic type and certainly just standard Medicare Advantage opportunities to do enrollments in some of those spaces and if it means slightly diluting our model, hey it's what we do already.

James Lydiard:

Everything's done in terms of a very specific patient. We do all of our own triage. Every patient gets a different visit type based on their frailty. So I think it's something that we can balance quite nicely. Then lastly this is more of the CareMore solution. CareMore is notorious for its Anthem affiliation but

recognize that in several states we partner with other Medicare Advantage organizations. So with a partner like Welltower if the building for one reason or another whether it be network or share of cost is not in that region or it's not an Anthem product that they would like there's still a CareMore health solution.

James Lydiard:

I wanted to talk on this slide too just real quick because one of the things that Welltower has also picked up on whether it's with their middle market capabilities and how CareMore could fit into a solution like that is I think we all know labor is likely the biggest driver of costs in the assisted living setting. When Welltower leaders on record are using Medicare Advantage as a way to offset some of those costs they're not just saying that a Medicare Advantage organization can come in and pay us. What they're saying is that can a Medicare Advantage that's mobile with scale offer up solutions where we could be offsetting some of their avoidable costs in the way of labor?

James Lydiard:

So to give you a good example of that, there are a couple communities in my home state, Arizona where we have over 100 Medicare Advantage residents within one single assisted living environment. We didn't just get there overnight. It's been a journey over a couple of years but in that same building now we pay rent. We popped up a clinic, we staff medical assistants that serve our members, not all members, but our members because we have enough of them. We have a pharmacy that goes into the community. We have podiatry that goes into the community. In many ways and in certain ways these are costs that the assisted living operator would have been likely affording themselves and I think that's what Welltower's looking at when it says that Medicare Advantage could likely shield the middle market communities from such costs.

James Lydiard:

I'm just going to close on one quick slide here. So we talk a lot and I've talked a lot at this conference about strategies, dollars, models. There's people at the center of all this. So this is a middle patient so meet Norm. Norm is 70 years old, he is a successful transplant recipient. Got that about 12 years ago. Here's on a Medicare Advantage supplement that he can barely afford. He's at the point in his life where he's really not able to drive much. So he needs transportation but he isn't that much higher than the poverty level. High enough where he won't qualify for Medicaid, not enough that he can afford most of his senior living options in his area.

James Lydiard:

You all are incredibly smart people that's something I've learned at this conference too. You could be in any industry you want but this is personal. So I think in the room, I challenge us all to sort of think about your Norm, so Norm is my father. Think about your Norm and think about doing this for the next wave of all of your family, your friends, and the people that we want to protect and make sure they have housing because Norm doesn't have... He's single. He doesn't have family. He meets a lot of your slide but that's I think why we're all here and hopefully why we're all committed to doing this together. Thanks.

Beth Mace:

Great. Thank you. Okay. So that was the formal part of the presentation today. Now all the panelists are going to get up we're going to walk the stage. This was project runway before so here we go. So now it's

really just sort of conversational. This is the town hall portion. So you can ask a question or you can make a comment and one or all of us will try to address that and if you don't have any questions then I have a whole stack to go. So let's see. Let's get the conversation going. That's what we're all about. Go.

female question 1:

The only thing I didn't hear you talk about is the debt piece of [inaudible 00:46:28].

Beth Mace:

The question was: one thing you didn't hear about was the-

female question 1:

[inaudible 00:46:34]

Beth Mace:

Oh, the debt. They come with debt. So how do we address that?

Diane Burfeindt:

I think it's all part of the affordability obviously I mean that's a huge component of it. I think that's why... I think in a lot of the solutions you heard here today especially when we're talking about Medicare Advantage really trying to lower that cost and also I think when I look at the interventions that we try to do to bring the silos together. I think there's a big cost reduction in there as well. As you were indicating the fee for service we just keep charging, charging, charging and I think what you see from the inefficiencies in the system it's actually costing these people a lot more because of those inefficiencies. So while they're coming to us with a lot more debt I kind of look at it that maybe that is why they are middle market and whatever we can do to on a healthcare side I think to try to minimize additional costs as well.

Kevin O'Neil:

Yeah. I think if you look at where things are going in terms of government subsidy and intervention. I mean there are programs out there a lot of people don't know about. For example, Medicare will now pay for people to be educated if they're obese about educating about good eating habits and for diabetes management. Some of you may not be aware that CMS has developed Accountable Health Communities now. 31... These are innovation sites that they started back in 2016 over the next five years it will be evaluating. They give a million dollars to each of those sites that develop Accountable Health Communities working with primary care providers and integrating various other agencies within a community to help address those needs.

Kevin O'Neil:

Obviously many folks want to stay in their home setting if they can which I think is great as long as they can interact because we know that if they're stuck at home by themselves they're not interacting with other people, that's really toxic. Avalere did a study several years ago I actually was part of that. They actually showed that by living in a congregate setting you can deliver all of these services cheaper than trying to provide all those services at home. One of my colleagues is a former president of AMDA and he said, "You know Kevin we have a million nursing homes... A million people living in nursing homes in the

United States. We can't afford a million nursing homes." And his point was to try to provide all these services on an individual basis in a home community setting may be very difficult.

Jan V. Eyer:

So Caroline and I have been talking as we were prepping for this session today and you talked about it really well in terms of how can you manage health and wealth simultaneously? So we need to create a sustainable... This is your quote almost. We need to create a sustainable solution for our nation's seniors' projected health and wealth characteristics that is affordable at the same time that sustains a high quality of life. You want to talk a little bit more about that?

Caroline Pearson:

Yeah. Well, I think it's interesting I see some faces in here going like, "We just want to be real estate people. We just want to be hospitality people and you keep talking to us about healthcare." I think that the middle market is the place where this intersection is forced. Because I said 20% of the middle market seniors are high needs. The 80% who don't have high needs they don't have a lot of extra money. They're going to stay home if they can so the folks where there is a market potential are the people who have some additional needs and who can really benefit from all of the additional supports that come with an assisted living facility. So I think it's funny coming from the healthcare space. Healthcare meanwhile has terrible hospitality right?

Caroline Pearson:

Talk to hospitals about customer service and you learn the other side of this equation but I think we, the healthcare community has finally woken up to, "Oh, it's not just what goes on in the hospital. People leave the hospital and then we don't know what they're doing and how to take care of them and the falls." I think the social determinants percentage, I think I'm at five. It's been presented five times today and we didn't do it twice in this session but it was twice in the deck. So people get it but how do we really begin to extend healthcare to the sense of health within where people live and integrate it into their daily life and make that something that actually reduces their medical expenses and keeps them healthier and wealthier longer per the conversation about length of stay.

Beth Mace:

And your final quote was to create an affordable living option that sustains a high quality of life that limits the need for more costly, higher acuity health solutions.

Caroline Pearson:

Yep.

Beth Mace:

Okay. Audience? Questions? Comments? Thoughts? Bob Kramer, you must have something.

Caroline Pearson:

There's one in the corner.

Beth Mace:

Oh, Roosevelt yes. Can you tell us who you are first?

Roosevelt Davis:

Roosevelt Davis, the head of Fannie Mae [inaudible 00:51:28] finance team. This question is for Kevin. Can you tell us what are some of your secrets of success for providing housing to affordable and middle-income residents?

Kevin O'Neil:

Yeah. Most of our communities in the state of North Carolina which is a pretty progressive state. So we've got both middle income... Obviously, our buildings were nice but they're not Taj Mahals. They were built well, safe environments. Again making sure we've addressed those needs of those individuals so again as I said before we convene all these services to try to keep them in place because again the most expensive care is hospital care and keeping them out of the ER, keeping them out of the hospital is really important to us. Our CEO is a very visionary guy. Charlie Trefzger really wants to disrupt the space in terms of being able to address the needs of this middle and lower-income demographic so he is convening other providers in the communities that we work with.

Kevin O'Neil:

So we have a lot of volunteers who come and help address some of those needs as well. Veterans benefits he looks into those. He really explores before they come in whether they can address those needs and works with the families on addressing the needs that they have. But again as I said before we've got more than 60% of our population's dual eligible so we're addressing the lower-income strata as well and I think he can create a model that other states can emulate hopefully.

Beth Mace:

Sorry. Can I put you on the spot? So we were at a conference a while ago, a NIC conference and it was talking more about the capital stack and who's going to finance it. So we talked about the capital stack for those of you who are unfamiliar with the term is who's basically financing it. So it's usually a debt piece and then an equity piece and then usually if it's a joint venture there's a piece from the partner as well. I don't want to misquote you but your thoughts on Fannie Mae and how much business does Fannie Mae do right now just with seniors' housing in general and then comment on what Fannie Mae would do in terms of middle market.

Roosevelt Davis:

[inaudible 00:53:46] about 3.1 billion dollars in seniors' housing.

Beth Mace:

3.1 billion?

Roosevelt Davis:

Billion. Yeah. B with the yeah. From our perspective, Fannie Mae part of our mission we're here to provide liquidity to the market that serve the underserved community. The middle income is underserved as well as affordable so what we're trying to do and what we're thinking about is trying to create a product to make financing easier for companies like Affinity that are providing low income, affordable, middle-income housing and care to residents. A lot of times when you speak to folks you hear, "Oh, it can't be done. You can't do this. Labor costs are too much." But from our perspective those

folks with the right minds and the right mindset if we get together in a room something can be figured out and Fannie Mae will definitely be at the forefront in helping with financing those types of properties.

Beth Mace:

Okay. That's what I was looking for. Yes.

Jeremiah:

How's it going? Jeremiah Sawyer, I'm a student at Cornell University of Hospitality masters program. So more inquisitive about when you talk about the seniors and I think of for example my parents who are close to retirement. Then a lot of what the need will be in 10, 15 years what are the preventative measures be it financial intelligence and when are they going to... For example, my parents now when they're about to retire so that way when they get to the point 10, 15 years down the line though they were teachers and operators of public transportation they don't fall into that lower-income need base situation. Simply because miseducation or not being fully educated about how they should approach retirement from the beginning. Then what are the products that are being made that would answer the question how do you get your parents for example out of a six-bedroom home into something that is what they would imagine themselves retiring in before they need to be in senior care?

Jeremiah:

To me, that seems to be one of the things that I see... An interesting product to be developed. An interesting need to be taken care of because you can get them out of situations earlier and their finances are better off and then they're in places where they're being able to be taken care of. As those care needs increase slightly they'll be more active and all the measures that talk about pushing the needs of... And life span and mobility back further just sort of taking care of at 55, 60, 65, instead of 80, 85, 90 when the actual cost they're putting on companies are actually going to be higher.

Beth Mace:

That's a great question and I'll start it and then I'll defer it to the rest of the panel. One of the things that we really wanted to get across in the message about the middle market was to be prepared so regardless if you're the adult yourself if you're a child of the adult, or you're the grandchild of the senior to talk now so you don't wait for an emergency. So you actually have a plan in place of this is what I want to do, this is the care I want, this is the care I don't want, this is how I want to live. So that you know that ahead of time because when there's a crisis you react in a crisis responding way. That's the first point.

Beth Mace:

The second one of your questions was how do you get people to actually move or want to move into senior's housing? That's a challenge. Now it's typically the case that if you talk to someone who's a resident in senior housing today they usually say, "I wish I had moved before." It's rare that they're not happy once they get there. It might take them a little bit to get used to it but once they get there. People want to stay and age in their own homes but the reality is that what it is and the data that we show is that people can't necessarily stay at home because their needs are going to be too significant to be able to allow them to stay at home. So there has to be a mind shift that they need a more institutional setting to be able to provide some of the care when they're older. Now in terms of being younger and how do you prevent that I'll defer to all you guys.

Diane Burfeindt:

Well, I think I'll just generally and then I'll turn it over to the experts but when I think about it... Especially what Andy just did right before this session when he was talking about his son with the broken left, right thumb. That's right because one of the... When you looked all of that he went through and this is a kid that has very capable adults traveling through the healthcare system with him and apparently some really good connections that can text MRI information to doctors. When you look at that and then you think about a senior trying to go through that same thing with a lot more complication going on than a broken thumb. I think what we see a lot times to your point as well right now your parents have you and you can help navigate that system. What we see a lot of times when seniors enter into our setting, they don't have anybody else to help them and so a lot of times the interventions I think that we can provide that are very helpful to the system are much like acting likethe adult daughter, the child that's really helping to figure this out and navigate some of this.

Diane Burfeindt:

So you have this overlay of an extremely complicated health system that doesn't work very well with multiple chronic conditions and then perhaps a lack of family support. So in a lot of ways, I think we look at ourselves as that adult child and what kind of things are we helping to replace or augment for them as well because obviously, they're not there. I think just one more point I would make I believe when we look at the future of sustaining what a CCRC is in the future I think it will be a place where you come for expert advice and coordination. I think the model definitely has to change what it used to be for with the silent generation and what they were interested in is not going to be the future but in today's day and age of the fact that you can Google anything and of course when you Google it, you know that you're dying of 12 different diseases all at once. I think people will start to come to us as experts to help get through some of this information and really help to make educated decisions. So that's why I hope people will continue to look for resources like that.

Jan V. Eyer:

I would just like to say I don't think it's just a system issue. So I have to ask you, do you have children?

Jeremiah:

No, but one of the things that is going on is I have a grandmother with dementia that my father's taking care of and my other grandmother who was in senior living in Florida didn't want to be there anymore. So now she just moved into my parent's basement, the mother-in-law suite a couple weeks ago. So I'm seeing two different sides of a similar problem with a similar demographic which is one of the things that's intriguing but at the same time, there's no singular product for example that if my parents were to move into they would be able to enjoy themselves the way my grandmother will be able to enjoy themselves. Though they're only 25 years apart if you will.

Jan V. Eyer:

So you talk a lot of the social issues. I just want to encourage everybody here who has children or who will have children so start talking now about what you want to do. Do you have your living will? Have you prepared? A lot of the time that is spent in Medicare Advantage plans and from primary care providers is talking to people about how do they want to live their lives. How do they want to live it over the next 20 years? So its incumbent upon parents even of small teenage children whatever to talk about where are you going to go and what are you going to do. Because there's not a big government or a

system oversight that's going to say this is when you should move into senior living or this is what you should do. It has to be a family conversation.

Beth Mace:

Bob Kramer.

Bob Kramer:

I want to pick up on Andy's comments. I want to pick up on Andy's comments at lunch. Some of the response it seems to me we've seen to the forgotten middle study has been on the one hand those serving the private pay senior market. So we're seeing the size of this middle-market let's sharpen our pencil, let's figure out how we can have a less expensive product so that we can capture some of this market. Then others who have traditionally been advocates and served the low income, let's see how we can use this to advocate for expansion of different programs that are designed for the poor. So that's low- income housing tax credits, that's Medicaid expansion. Each of those would seem to me in Andy's thinking at lunch are examples of where you're trying to in a sense do better or more efficiently the same product you're already doing.

Bob Kramer:

So what I want to do is ask the panel to comment on the idea which I think is a little more of the direction that we don't know many details that Welltower's trying to go. And that is let's set a price point that we say based on evidence is what this typical middle of the middle could afford. Let's include in that they're out of pocket costs they're going to have for copays and deductibles and anything else like that. Let's then set a price point and say how can we deliver a product that is going to meet their needs at that price point. I'm concerned that so much of the response so far as I said is being seen as opportunities to expand what we presently do by tweaking our current product or tweaking our entitlement programs or benefits. So the last thing I'd say in posing a challenge to each of you is how will you do this without the fallback, the automatic fallback that people will go on Medicaid when they run out of money?

Bob Kramer:

Because that is a cop-out. I'm sorry I'm just being provocative. But what I mean is that's assuming that ultimately that you're going to use the government's support programs that are already out there and you're going to grow them hugely to serve the middle income when they reach there. And that won't I think... So how do we serve this population, this middle of the middle how do you react to the idea of let's set a price point and let's get the most creative people we can band together and figure out how we're going to deliver at that price point without the majority of the folks having to end up on Medicaid?

Beth Mace:

So let me just start as background to the audience, in our study we assume that rents for the year are about $55,000 of which $5,000 are of out of pocket medical costs. So $60,000 a year that's roughly $4,500 a month. That was our base case assumption and with that assumption, we were able to show that 46% of the population of middle income that Caroline defined could afford the senior housing that we traditionally have today or conversely 54 could not. So that was again at a price point of about $4500 a month just for context. How do we get something that's less than that to address Bob's question?

Kevin O'Neil:

Yeah. I think Bob I'm really encouraged by the accountable health organizations because the reality is that the number these folks that are ending up in the hospital the charge, the expense that has to the system is extraordinary. I think you've all heard that a third of Medicare spending is waste and fraud and that's absolutely true. But the whole idea behind that is engaging not only the primary care providers in a community but also to engage other services within that community to make it a community effort to address the needs of that population. It will be really encouraging to see it.

Kevin O'Neil:

It was mentioned at lunch today: the hospital home project. Bruce Left's work on the hospital home project has done extremely well in terms of keeping people out of the hospital at much less cost and we don't have all the complications that are associated with those hospitalizations. So I could see where we could have again a reasonable living environment. No one at that price point is going to be able to afford to have their own nurses and have their own staff but you're going to have to be a convener to be able to address those needs and keep these folks in that environment without ending up at a higher level of care. Because they won't be there very long I think as we've mentioned today most of them are going to have multiple chronic conditions and multiple... They're going to be at high risk for these other issues. Mobility, mentation issues and so forth. So we really need to look at the community health resources. America's got to have a soul. I mean we've got to realize that this is a very vulnerable population we're going to be dealing with and we're going to have to solve it on a community level.

Jan V Ever:

Thanks. I was just going to say, James could probably speak to this. The exciting part about the Welltower piece or... Accountable Care Acts are all the medical people jumping in. But Welltower's talking about is a community how does everyone sort of take risk and how does everyone look at the financial piece of it? And I think James's group is doing some of that.

James Lydiard:

Well, we're taking initial strides and I certainly am not going to speak for the Welltower team who is here to some extent and would probably be able to engage much better. I also think that there's been a lot of great articles just even since the release about certainly things out of my world but space reuse, rethinking meals in the senior setting which is another cost driver. These are all the care things that you've just heard up here. These are all ways to subsidize the builder, owner, operator in which to pass along savings to the middle that can now afford it. I think it's going to take that multi-industry mindset think tank that I think was called that over here too by Roosevelt. But I think it's going to take everybody in the room to sort of say, we all agree that this is missing and here's what we can contribute in the way of innovation or using a government fund here.

James Lydiard:

Using another great article, using special interest groups. What could be funded from a Parkinson's specific housing? Or housing for blind? Or deaf? Or how could you take the first floor of your community and turn it into a rental space for any and all small businesses to come? I mean these are just a ton of different strategies that I think have to be considered. Are any of them right? I think it's going to end up being a regional answer. Somebody called out regional. This isn't going to be perfect for everywhere but I think you're going to have to find these businesses, find these think tanks in your market and see what can come about so that we're not taking an operator and just diluting something or taking an

operator and enhancing something and we're basically just doing the same thing we already used to just for slightly higher or lower cost.

Beth Mace:

It is pretty hopeful that CMS has actually now announced things that they're working on to support population health and management. As an operator, you're going to get paid for things that you couldn't have prior.

Diane Burfeindt:

I think to your point Bob about creativity I found our most creative work is in affordable housing because you don't have the option of money. As a limiting factor, it really makes you go out and look at a lot of what you said here today you go out and look at who else is in the community already doing what you're trying to accomplish. So much I think in at least our world and CCRC and private paid housing... Our background is in care. So we kind of think that whatever it is that is needed that we need to do it. When you get into affordable housing and there is no money and you have to solve these issues and try to keep people in your building without any money you get really, really creative and I think you start to look into the community. You start to see who your partners are. Who's doing this really well and in some cases, we have a much more robust program and affordable housing than we do in a CCRC because we're getting to the root of the problem.

Diane Burfeindt:

We're not trying to solve every problem, we're trying to solve the most prevalent problem for our residents. So I think that's really important and then the other thing I see in our organization is that intersection between our own silos. So the expertise of affordable housing so we have service coordinators in all of our sites and by the way, our affordable housing also hits the middle market quite squarely. We do tax credit housing but when you look at what these service coordinators do in the community and for our residents where they're actually giving them access to resources they're not providing the care themselves. Take them and put them over into skilled nursing and teach them how to do that same thing. I find even with our own system we have these silos where we're not learning from each other and really utilizing that expertise. So I happen to think there's just so much waste in the system that if we did more of that together and really tried to squeeze out the waste I think that's where some of the funding comes from as well.

Bob Kramer:

I would just add for those who come from the traditional senior's housing background the interesting thing is when Welltower talked and what they've said so far that one of the keys is that they'll be very little staffing in these buildings. Very little staffing. Very low staffing ratios. What I was reminded of is how we're going back almost 30 years to the original Bill Colson holiday model. Where you had a live-in couple that were basically sort of the service managers and then they had a relief couple and that was the staffing in the building. They provided the meals and transportation and so forth. That was a middle-market product that Bill Colson designed and it was designed to serve the middle market. But the difference today is the interest of those who have the healthcare premium risk for those people that are going to live in those buildings and the way that you can structure it seems to me, a wrap-around Medicare Advantage product that can meet those healthcare needs of the people in the building which that holiday model was not designed to address. So to me in one sense we're going to back to the roots of private-pay seniors housing with the original holiday model but we're now going to do it in 2020

where we now have a great interest of healthcare payers in how we can basically keep people healthier for longer at less cost.

Beth Mace:

Okay, we have some questions. Yep. Alan.

Alan Lynch:

Alan Lynch Nixon [inaudible 01:13:00]. So I just want to pick up on something Bob said and to contextualize this, this would be for example a provider who is developing a new community and trying to do Holiday 2.0 they would never say it that way. But a community where people age in community and want to stay there and are able to stay there. Specifically on the pricing one of the issues that doesn't really get a lot of attention obviously labor costs are pervasive but food costs. So providers I work with are constantly struggling with issues around food costs and when you talk about that in the context of middle-market you really have to sharpen the pencil to the point where there's not much pencil left. I'm interested in creativity and innovation when it comes to food costs and delivering a middle-market product at a price that the middle market can afford.

Beth Mace:

Any thoughts?

James Lydiard:

I'll just make a quick comment and that is that I think our Optum, Jan called it out earlier. Currently, I think a lot of the Medicare Advantage solutions the food is medicine sort of themes that are out there have a lot more to do with post-acute changes in condition, limited timeframe, meal supplements to allow somebody to get home from a hospitalization or a SNF. And not have to think about the grocery as opposed to let me just get better for 10 days or whatever it may be. Again this was well-published nothing that I'm coming up with but I think that the Welltower model would include some of their own assets so they made it public. There's a company called Luvo that's doing freeze packaged meals that don't take staff to heat up and these aren't your typical TV dinner. They're at Whole Foods. They're bought in bulk. They're mailed. There's a lot of ways to ship as well. These are some solutions I think that are coming from the housing market.

James Lydiard:

There are some solutions coming from the Medicare Advantage market. They'll need to be blended because frankly even other Medicare Advantage programs and supplemental benefits that have expanded recently to include things like housing respite. That's not long term. These are 10, two weeks stints that are here to help somebody sort of get back on their feet but they're not anything that's going to support a patient long term and they're certainly not going to shield what you call the Medicaid backstop in this either.

Diane Burfeindt:

I think you're talking about food costs in relation to providing the food onsite. I flashback to probably to 10 maybe 15 years ago we have a very small middle-market rental in the middle of St. Clairsville, Ohio. So many times we sit there and we have these thoughts about these big issues but then on the ground, there's real issues and they wanted to start providing meals to their residents. Actually, they had had a cook there for quite a long time. Of course when you have one cook for quite a long time that person's

going to leave at some point. And what they did was they developed a relationship with a local restaurant who came three days a week and did onsite catering. Again when you get back to mutual benefit it was serving the community, it served the restaurant really well, it served the residents. They didn't have high expectations of what they wanted but what they got was really good high-quality food. Things like that extend to at one point they were providing transportation and their bus broke down. Severely broke down to the point where there was no more bus.

Diane Burfeindt:

Couldn't afford to have a new one. Couldn't support it through rents or anything like that because we wanted to keep it really affordable. Just so happens that their volunteer ambulance company was having issues with also affordability and staying alive so they developed a partnership with the local fire department to do their transportation. So I think Bob to your point going back to the old days some of this we've gotten too smart for ourselves almost and some of these solutions are just in the community themselves and trying to help each other-

Beth Mace:

Or Meals on Wheels or less expensive food choices.

Diane Burfeindt:

Exactly.

Beth Mace:

Or even to the point of depending on the acuity level of the facility or the property having people pitch in and do meals themselves or having volunteers do things is a project in Newton I think. Alan [inaudible 01:17:30]

Speaker 12:

So this next question is for James.

Beth Mace:

Okay. Sorry.

Speaker 12:

I have two questions, the first one's real easy. What is your Medicare Advantage cap rate in the area you're at... 10,000? 12,000 a year? 14-

James Lydiard:

You're asking what our Medicare Advantage RAP score is and our revenue is?

Speaker 12:

10,000; 12,000; 14,000 like how much do they... For example-

James Lydiard:

So Medicare Advantage organizations, Anthem and CareMore included for IE-SNP populations are typically working on RAP scores at about 2.5 which equates to about $2500 pmpm for a nursing home patient. That's a mature well-coded patient at the highest level of specificity and for the AL, IL sort of population, you're probably looking at about a 1.95 to two which ends up equating to about $1600 to $1700 pmpm that's-

Speaker 12:

1600 to 1700 a month?

James Lydiard:

Per member per month.

Speaker 12:

Okay, so you're looking at let's just take 2000. All right. Just round it up a little bit for an AL so 2000 times 12 that's $24,000 a year.

James Lydiard:

Mm-hmm (affirmative).

Speaker 12:

What I'm trying to figure out is the 85 cents is what they're going to maybe give to somebody if we're going to take that over. So let's say we can do it for 65 cents by providing better care so we have 20 cents so we're getting 20% of that $24,000. That ends up being $4800, how does that help much? It's $4500 a month to take care of these guys, five grand. I don't get it. I don't follow what you guys are talking about on this Medicare Advantage carving out 20% at which it'd be pretty aggressive of $24,000. How does $4800 really going to help much? Thank you.

James Lydiard:

Well, I think what we've discussed here is it's not certainly a sole solution. I think where Medicare Advantage is coming in is to try to extend the length of stay of a private pay resident and we have the data to support that. I think what we're also showing is that where we see value in assisted living operators saving dollars that would have otherwise been incurred because of a hospitalization or something else where the Medicare Advantage organizations is who's at risk. So we can talk about how much money we make per patient but we can also talk about how much money we lose if the patient goes sideways. I think for those folks we're also looking at things like quality bonusing and looking for things like how to reinvest in the community that's caring for that patient 24/7 as opposed to us who come in even proactive and preventively. I think that's probably the area that we have the most to grow in and maybe an area that we need to take some of what we've learned from skilled nursing operators that are in upside shared savings agreements and begin to apply those toward assisted living. I think that's really going to be the direction for many of the IE-SNP programs in the future.

Speaker 12:

Thank you.

James Lydiard:

Yeah.

Beth Mace:

Okay. So we only have a few more minutes. So I have time for one or two comments or questions. Go ahead.

Loren:

Oh, great! Thanks! My name is Loren. I run a small not for profit system in Rochester, New York so we're a regional operator. If I can get my voice here. My question but I don't want you to answer it yet deals with social isolation. I think you all talked about Medicare Advantages and things that it will fund so I want to return to that. But Bob awakened something in me. To backstop Medicaid and the conversion of people from middle income to Medicaid we have established a [inaudible 01:20:54] program. So we will subsidize people within our system if their health needs haven't changed. If you were to think about as a for-profit operator taking one, two, 3% of net profits and putting them in a fund and then using that fund to support people who's needs but resources are driving a change of level of care. I offer that as just a suggestion.

Loren:

Secondly, five years ago we decided... We are developing vacant Catholic schools and Catholic churches so that our cost to develop affordable senior housing could be someplace in the neighborhood of 100,000 to maybe 125,000 per unit. So that we could cap the debt service and obviously then cap the rent. Any of you that are in a community that has schools and churches to sell I don't think you always have to build new to meet neighborhood needs.

Loren:

Then my third point is we started a neighborhood program in each of our nine neighborhoods. We want to know the people living in their own homes within a five-mile radius, how many have lost a husband or a wife or have just been diagnosed with cancer and how can we engage them in social programs to keep them out of the medical system? So again back to the question, is there any information that you can share on how social isolation leads to deterioration over time?

Beth Mace:

We'll come to that but in terms of you reusing the space that you're talking about, there's a lot of discussion to reuse the class B malls that have closed. A lot of space or even older senior housing properties to repurpose them because of the cost basis. Because you can lower the cost basis and then to your point you can lower your debt service and then you can lower what your rents are. So that's definitely a big conversation that we're having in terms of the adaptive reuse of space. Then...

Kevin O'Neil:

Well, when it comes to social isolation there's an ample body of research now showing the impact on cognitive function on myocardial infarction risk, stroke risk, depression, and even Alzheimer's disease on dementia risk. So clearly I think as was eluded to before I think we as senior living operators have an opportunity to extend beyond our walls to become a resource to the broader community. Invite people in to share information and education about these types of issues and build that reach out into the broader community. I think the interaction with the area agencies on aging the other organizations that are supporting services in your community is really important.

Kevin O'Neil:

I know in our community where I live in Sarasota, we have it's called a Senior Friendship Center. We've got a bunch of volunteer docs providing free services. They're under a limited license because they were going to retire but they really didn't want to retire and here are these great docs that are providing free services to those who can't afford it. We've got the Meals on Wheels program. You're probably familiar with the Dallas experience with that. The money that they saved in terms of healthcare costs was extraordinary. So this senior service organization is now expanded to five counties and I think we have a real good opportunity to tie in with community based senior service organizations to disseminate the word. They also can identify those folks out in the community who may be getting to the point where it's not safe at home any longer or they just don't have the social support at home that may be an opportunity to bring them into a congregate living environment. So hopefully we can all figure it out together.

Beth Mace:

Okay. So to wrap up I'd like each of you panelists to make a comment if you can in terms of reiterating or something new in terms of what we can do collectively or individually to try to create solutions on the care side of the formula of the equation. To try to address middle-market and senior housing needs.

Diane Burfeindt:

I'll start. I think I mentioned it very early on. I think data is huge. Somebody mentioned early on that managed care organizations would want to partner with senior living because we have all these people living with us. The problem in my experience is they can't see all those people living with us. So the way their data works they see individuals that they're treating or having claims data. They don't necessarily see that they're all living with us and so I think the more our world extends to be able to share information and really being able to see solutions in a very different way where you're above looking at where all these people are. I think some of these things will become even more obvious.

Bob Kramerl:

Yeah. I'll just make a comment. When it comes to data, Dr. Deming once said, "In God we trust. Everyone else must bring data." Because your value is only going to be shown by your data and for those of us in the senior living world the things you want to be capturing now to become a valued partner are going to be not just readmissions but unplanned hospitalizations. Again that's an index event that's [inaudible 01:26:20] event for an older adult. Likelihood is they're going to have other subsequent hospitalizations and the time to intervene is before that happens. NCAL and ACA have published these guidelines and things you should probably be gathering right now. In addition, the GAO, the Government Accountability Office just a couple years ago said targeted senior living operators around the antipsychotic use. The broader issues related to pharmacy but anti-psychotics have a toxicity that's significant. So gathering that.

Kevin O'Neil:

But they also want to know about your staff retention because more important than the building as important as that is the environment. More important than your programs even more important than your food is having a stable, consistent, compassionate staff. That's the most important thing to the quality of care and the customer experience. You want to gather your customer experience too. Those are the things. There are other things the metrics but those are the basics right now is to gather those four or five key metrics.

Beth Mace:

Anybody else?

James Lydiard:

Yeah. I would just say that some of the things on Medicare Advantage that we've talked about now at length are certainly not here in today's day and age to set up a program to start funding a lot of this or reimbursing assisted living probably for the value they are providing tomorrow. But what they can do today is shield seniors from avoidable healthcare costs. Be proactive, be preventive, provide onsite staff when possible and that will either reduce the current exposure that your seniors and your communities do have to avoidable medical costs. Start providing more proactive, more innovative care delivery programs and solutions that are starting to touch on the housing piece and the food piece and all the social isolation pieces. So I do think that Medicare Advantage and certainly value-based providers and care organizations ought to be part of the middle in which to shield those healthcare costs.

Jan V. Eyer:

I would just add one thing that's a challenge that I think Bob and several people have referred to there are a lot of anecdotal solutions in terms of what you do in communities. The real challenge for us is how do you scale that? How do you have enough population, enough solutions in one place that you can use in your and I can use in the West and we can use in the East? How can we scale things to make them more financially reasonable?

Caroline Pearson:

I am thrilled that the healthcare system has gotten outside its own four walls of the hospital and that the MA plans are so excited about all of these things that you guys can deliver. I think to the question earlier average rebates in Medicare Advantage in 2019 are about $122. That's to pay for dental, vision, fitness and then all those other exciting new-fangled things. So there's not a lot of money here. It's really important that we're all focused on the same issues but we still have a payment gap and I think we need to breakdown the sort of policy and industry barriers and really focus on how we get those dollars to the folks who need them.

Beth Mace:

Okay. Well, thanks very much. Audience you were great. This was a good town hall. Thank you, panelists.