Super Session: Five Healthcare Trends You Need to Know

Andre Maksimow:

My name is Andre Maksimow and I'm with Kauffman Hall. Really excited to be here today with you all right now and talk about five healthcare trends that we are about to present to you here. For me, it's particularly interesting and exciting because in the 2000s, I spent a lot of time in senior living. I was headlong in senior living, CCRCs, and kind of focused on that segment of business. And then since about 2010, I've been primarily focused on hospitals and health systems. For the last 10 years, it's always been the two worlds were always separate, they never crossed, but now they're starting to become a lot more momentum right now where those two worlds are now starting to combine in a much more meaningful way that I think makes this really exciting. Really look forward to getting to know all of you a little bit further and talk about some collaboration opportunities.

Andre Maksimow:

Today's format, if you will, what we're going to do is, I'm going to talk for about 35 or 40 minutes, just kind of set the tone a little bit, describe the five healthcare trends, give you some background information and then going to ask our panelists to come up here as well. Then we're going to have a bit of a free- form kind of dialogue, ask some Q and A. Then what I'd like the audience to do then is, after we go through it, I think there is going to be microphones on this side and that side, so please feel free to interject and ask some questions. We'd love to make this as interactive as possible.

Andre Maksimow:

The five trends that we're going to go over today. These are the ones that are listed and the way we view this from Kauffman Hall's perspective is that the primary trend that's really causing all these changes that are going on right now is that, put quite simply, healthcare is just too expensive here in the United States. Simply put. The growth trend has been unsustainable. There has been lot of pressure on the government, employers, all the while and this trend really can't continue. Or at least that's what we thought 10 years ago, but it still has. Anyway, that's the overarching trend that is really driving a lot of the changes and then perhaps these other trends are more result from that overarching trend, which is the emergence of the healthcare consumer. You never, or at least I never thought I'd hear healthcare and customer satisfaction or consumer in the same sentence, but now that's becoming a lot more common. We'll talk a little bit about that.

Andre Maksimow:

Some major changes in healthcare delivery. I think the traditional way of thinking about healthcare delivery was you have your community hospital, you have your doctors and physicians, and that's always the way things were done. And it wasn't really accessible, wasn't quite convenient, but for whatever reason we all tolerated it and we continued on, but now things are definitely changing in that regard and there's some pressures that we're going to talk about in a little bit further detail. Finally, we're going to wrap it up with some potential disruptors, give you some ideas, some of it might be a little provocative, may or may not be, just to give you some food for thought. And then finally, we're going to wrap it up with why scale matters.

Andre Maksimow:

In senior living, I know there's a lot of transactions that go on, 3 to 400 per year. In health systems, there are a lot of transactions going on as well, but what you're seeing is larger and larger deals because, quite frankly, the smaller players really just can't survive right now. And there's a lot of forces at work there

that we're going to get into a little bit more detail. That's the agenda and let's go ahead and jump right into it.

Andre Maksimow:

This is probably a graph you've seen quite often, the cost of healthcare, how it's growing, et cetera. I think one stat that always resonates with me is, number one, since 1970, if you look at a 50 year look, healthcare inflation has been about twice the overall inflation rate and that's what's led up to this going from seven to almost 18%. So systematically each year, healthcare inflation is going up by two times inflation or something more than that. And what that's doing obviously is, as each year goes by that's crowding out more and more discretionary income, more and more tax dollars, more and more things that could otherwise be used for other uses. A common question we field is, being in the healthcare business and focusing a lot of our not-for-profit health systems, sometimes the question is raised, what's so bad about this, frankly? Healthcare is a generator of jobs, it's a big part of the economy. Why not continue this on? [inaudible 00:04:28]

Andre Maksimow:

I think the major factor I think everyone pretty much agrees upon is that it's just in essence, a tax on the system. A tax on our economy. It crowds out investments and other things that are worthwhile. And quite candidly, US healthcare, if you look at it from a broad spectrum, it's not great. We're probably one of the highest cost, we have some of the poorest outcomes overall in terms of life expectancy and healthcare outcomes. We don't do a great job of it and the questions then become, why is it so, we'll get into a little bit more detail here, but largely the reasons for that is, number one, US healthcare, we probably have the highest prices in the world, put simply. That's one of the major drivers there.

Andre Maksimow:

And then the other two drivers, which perhaps are getting a lot more attention now is that, in essence we really have a sick care system for lack of a better word. What I mean by that is, historically the focus has always been on treat, surgery, treat. Something is wrong with you, go in, get something treated. It's never been focused more holistic on care management. For example, 80% of folks over 65 have chronic disease. There's not been the incentives from a reimbursement perspective or otherwise, to actually treat those folks more holistically and treat their chronic conditions which ultimately will lead to more downstream type events. And that's not occurred. In general, US healthcare, a lot of problems. That's kind of the macro view.

Andre Maksimow:

Moving on, just looking at this from a consumer perspective. Here are the key takeaways from this slide. Number one, healthcare costs going up, we've talked about that. On the employer side, in general, what's happening for consumers are that, number one, it's going up, but the interesting this is it's going up for the employees themselves. Give or take from 2008, 26%. Now you're taking the 28%. The other aspect of this, which is pretty important here is that deductibles are going up here as well. So in essence, you're paying more for less insurance. You have more of a deductible and the reason for that is by and large, employers right now are deciding, it makes a lot more sense for us to put out a high deductible health plan that's going to be cheaper and hopefully our employees are a little bit more prudent with their healthcare dollars. Now they are actually putting the healthcare dollars out a little bit more sensitive to it, perhaps there is more ... at least the idea is that be more judicious with your healthcare dollars and you'll do some more shopping.

Andre Maksimow:

I think that kind of brings us out to the first polling question here just to get a sense of the room. We have it right now. This audience, at least, is a little bit below where we see nationwide trends for whatever particular reason. We've talked about it before, it's about 45-50%. But in general, what we're seeing is that the prevalence of high deductible [inaudible 00:07:18] is probably not abating and that's a major reason why we're going to get into the next segment of why consumerism is really becoming more of a focus.

Andre Maksimow:

Consumerism. The simple way to think about it is, from a consumer standpoint, the things that really matter are, number one, access, when can you get the care, how can you get the care, when do you need the care. The experience, again like I mentioned before, traditionally, in healthcare, the notion of customer experience or kind of the focus there has never ... really been non-existent. Now, I think with the push with millennials, they have everything on demand, when they want it, how they want it, they are the largest age cohort right now so what health systems are doing now, they are really making some fundamental changes to the way they are operating.

Andre Maksimow:

Lastly is the cost equation, which is probably, again, the theme that runs through many of these slides right now. Things are just too costly and what's going on right now in the industry is there's definitely more of a push towards price transparency. There's obvious constituents that are opposed to this for various reasons, but nonetheless, not the easiest thing to do to figure out what your hospital charges for one procedure versus the other and go shopping. We'll talk about that a little bit further.

Andre Maksimow:

At Kauffman Hall we do a survey each year and we survey healthcare executives and we also survey some healthcare consumers and we just try to keep our finger on the pulse of what's happening right now in terms of what are the trends right now in terms of access and convenience and the ability to get your healthcare in more innovative ways. To run through this briefly, virtual care, that's the likes of Md Live, if you guys have heard of that. Being able to actually access a physician through your computer on demand, it's about 25% of our consumers say that they strongly agree that that's available. In terms of being able to schedule an appointment during nights and weekends, that's about 40% and having overall access to get care without a scheduled appointment, that's becoming a lot more prominent too. Probably the best example of that is, I don't know if you guys are familiar, but some of the urgent care locations that are popping up right now and more of the retail locations. You get the healthcare when you want it. Finally, the ability to schedule visits online. This might be a bit of a misnumber here in terms of 49%. This is largely just for patients that are existing patients of a health system. I guess the takeaway here is, from our perspective things aren't really quite where they should be, but they certainly are getting better.

Andre Maksimow:

This is perhaps one of the more interesting slides here in the deck. Just to give you some background, I work with a fair amount of different health systems, predominantly in mergers and acquisitions and some of this data was passed along to me from a CEO of about a $1.5 billion health system we talked about a little bit. Just to kind of ground you, here's where the data came from. A bunch of self-insured

employers came together and said let's do a study and try to probe and figure out what's exactly the pricing differences by hospital but then also by geography here too across America.

Andre Maksimow:

Here's the key takeaways here. For those states that can get a pretty good data set, I think it was something in the range of $13 billion worth of healthcare spend, about 4 million enrollees and what they focused on entirely was just hospitals because from their vantage point they felt that hospitals comprise about 50% of the spend, that's where they should focus their efforts on. The takeaways here I think are, for those folks that perhaps live in Indiana, not great news for you. You have the highest cost healthcare overall in terms of in-patient/out-patient care. And for those that might live in Michigan, you actually have, at least from the prices of the providers, the hospitals, they actually charge the lowest. There's all kinds of different reasons why some of those dynamics might be going on, but I think the key takeaway here though is, and to explain this just a little bit further, what these percentages represent is, what the study tried to do is calibrate the costs to Medicare. They tried to take a common denominator and take it all down to Medicare so there would be easy comparison points and benchmarks going across all the hospitals. This is where the results came in. It varied in-patient/out-patient between 150 and 300% of Medicare.

Andre Maksimow:

The chart on the right, I think, is a little bit more interesting here because what this really shows is, we talked about in-patient/out-patient, but now just focusing on out-patient, this is where you have some significant diversity in terms of pricing. The variation is just absolutely incredible in what this study found. I know you can't see this on the screen. We'll go to the next slide. But basically what you have here is along the bottom are the states that were studied in order of increasing cost. The cheapest, again, was Michigan, the most expensive, Indiana. We're going to focus on Colorado just for a minute here, but to key in on Colorado, you have a pretty good data set of claims that they looked at and what you really see ... Here's the headline that came away from it is, hospitals in that region, at least for out-patient charges, they range from between 100% and 800% of Medicare.

Andre Maksimow:

To boil that all down for procedures like imaging, lab tests, whatever you might get in the hospital, it could be eight times as expensive in one hospital versus another in Colorado. So that's where you're seeing a lot of that variation. That's some of the underpinnings right now, some of the key drivers right now where we're focused on disruptors and others are trying to get to in saying these differences in prices really don't equate to quality so how can we get at this to perhaps save some additional dollars.

Andre Maksimow:

The next question here from a polling perspective is, the question is, now that you heard some of this data, maybe some of you practiced this before, but would you actually go out and research the cost and/or quality of care before you got care for some low acuity type services. Would you actually do that or in fact, would you just take usually the physician referral and the recommendation rather than doing that? So maybe a quick ... Wow. Okay. Wow. The results are bouncing around but it looks like it settled in at 33%, 40, even further. Let's call it 40 here for argument's sake. That's probably generally what we're seeing around the country right now too is in terms of folks actually going out and research. Not getting into a big discussion about this, but the one thing you can take away from this conversation is, before you just accept the referral, if it is a procedure and you have a high deductible plan, call up the

hospital or call up the provider and ask what is the cost of this particular procedure. They will generally give you the answer to that. They can't tell you exactly what your out of pocket will be otherwise, but they can give you the headline cost of the procedure.

Andre Maksimow:

And I think, at least from our prospective, that's a long way from where things went because four or five years ago, if you actually asked the hospital, what do you charge for that procedure, they would shrug their shoulders and say, "I don't know. We'll tell you in about six weeks when we give you the bill." That was the answer so, anyway. I thought this was an interesting takeaway here for this group.

Andre Maksimow:

We talked about the consumerism, changes that are going on, the overarching cost increases. Now in terms of healthcare access and delivery, what's really driving those changes? Not to belabor a lot of these points but, traditional healthcare delivery is being pressured by a lot of different data points. We just talked about consumer expectations. Folks are looking for things more on demand, more when they want it, how they want it. Health plans and employers, employers are at wits end right now in terms of healthcare costs. By and large this very favorable economy has probably mitigated some of their efforts. The employers have not wanted to disrupt any of the health plans for fear that they can't recruit the right employees, but if the economy does end, you're going to see more of the employers getting a little bit more forceful and then finally, the government, whether you like the administration or not, the current administration in force right now, they are really having a big push right now in terms of price transparency. One of the things that are up for grabs right now is that hospitals will be required to put out pricing, not what they charge necessarily, the gross charges, but actually what they get paid from insurance.

Andre Maksimow:

Right now, this is in litigation. As you can probably guess, the hospital lobby, the American Hospital Association, isn't really in favor of this rule right now so that's going back and forth. But from our vantage point, we think that a lot of these differentials aren't sustainable. And then finally, there are some healthcare disruptors that we'll discuss.

Andre Maksimow:

In terms of healthcare delivery, just to explain this a little bit further, maybe it's not conventional wisdom but in general, in-patient or entering into the hospital, that utilization is going down significantly, has been going down for the last 10 years. For most hospitals right now, they are quite hurting right now that more and more people don't need the in-patient services so you don't need to be checked into hospital. You can actually get a lot of the services done on an out-patient basis. The best data we could find is Medicare to illustrate this point and what you see on a per capita basis, at least over the last 10 years, is the amount of out-patient visits have gone up 43% and in-patient has gone down by about 20%. The takeaway here is, for those that are trying to track hospitals and try to understand the business a little bit further, in general, across the country with the exception of some of the sunbelt states, in-patient admissions, a major driver of their profitability, is all going down right now and they are switching over to out-patient but nonetheless in-patient is definitely taking a ride down.

Andre Maksimow:

For this particular group, we thought it might be interesting to take a look at home health utilization versus skilled nursing. Are a lot of those trends true here too? So is care going to the lower cost setting, this is the first time we looked at this data. I expected there to be similar trends and there are. We have to do a little bit more math here to figure out what these trends were, but in general, from the last 10 years taking those same data points, what you see is skilled nursing on a per capita basis has gone down about 16% and what you see is home health episodes on a per capita basis have gone up by about 10. We tried to get rid of some of the noise in terms of the fraud that goes on in home health, trying to remove those states that perhaps have suffered some of the most fraud, Florida, Illinois, Michigan and Texas, and that bumps up to 10. Needless to say, whether you talk about hospitals or you talk about skill ed nursing and home health, care is definitely going to lower cost settings. More convenient lower cost settings and that's what is happening.

Andre Maksimow:

Now that we've discussed some of the care delivery and some of the other forces that are looming, here are two companies that frankly, a lot of healthcare executives are staying up worrying a little bit at night is United Healthcare and their Optum Division and also CVS/Aetna. United Healthcare is obviously a household name, but Optum may not be so what Optum is, is it's a separate business, separate subsidiary from United Healthcare and what they do is their mission, if you will, is to provide data analytics, they provide information to payers, other payers, and also health systems, but the other thing that they are doing right now is, your insurance company is basically getting into the provider business. They are going out there right now and buying up a lot of providers. They've gone on a systematic acquisition spree for the last three or four years and they purchased a significant amount of physicians, they purchased ambulatory surgery sites, they purchased urgent care and they also even purchased a healthcare consultancy called The Advisory Board.

Andre Maksimow:

Their simple strategy is looking at it this way, they want to be in the top 75 markets by population and they want to control the front door from a physician's standpoint and redirect care to anywhere but the hospital from a cost perspective. And that's the grand strategy from Optum and United Healthcare. CVS Health, they've recently made some major shifts in their strategy. What really prompted this was the fact that they bought Aetna. Now you have the reimbursement side of the equation covered and there's all the incentive in the world right now for CVS to start thinking about, hey, maybe we should get in this provider business right now. Traditional healthcare is probably not serving the needs that are needed out there, let’s get into this business because quite frankly, there's about 11,000 locations nationwide, they've got a huge footprint right now and I don't know what the exact stat is, but I think something like 80% or so of the population lives within a five mile distance of any one particular CVS. They have all that infrastructure out there right now and what they are deciding to do is, you guys are probably familiar with Minute Clinics, you've seen that. You might have used them from time to time.

Andre Maksimow:

Minute Clinics are largely just a nurse practitioner, they really don't do much aside from prescribing antibiotics, maybe a flu shot, something very quick. But what CVS Health has done is, they've decided, you know what, this concept of lets completely reinvent the front door of healthcare. Let's really put a lot more investment, put more providers, put more resources into our stores and more focus on chronic care management because, again, they own Aetna, so they have a lot of these folks that are insured. They provide the care, they provide things to their insured population in these stores. Hopefully, the

idea then would be by offering this care on a much more accessible basis avoiding the hospitals, you can bring down the overall cost of care and that's their strategy.

Andre Maksimow:

I'm not sure if anyone's seen any of these right now, but they are going on a systematic rollout of about 1500 of these new Minute Clinics on steroids, if you will, these health hub stores going across the nation and here's a listing of some of the services that are being provided. So far, from what we understand, the uptake has been incredible. Consumers have really been happy with the services, the performance they've received. Again, the ability for CVS to do this almost overnight in one year to roll this out across the country in about 15% of their stores. That's pretty daunting when you think about it from a health system executive perspective. Nothing happens in health systems overnight. Things always take time to kind of go through in planning and strategies. And for this to go on and if the version goes on that they are expecting, this again, as I mentioned before, is a pretty major issue for them to contend with.

Andre Maksimow:

The last trend that we're going to talk about here today is potential disruptors. Okay. I got the wrong one, sorry. Again, the consumer survey that we talked about before that Kauffman Hall does each year, what we wanted to do was get a sense of not whether people use Amazon, Google, or Apple, obviously everyone uses them, but from a consumer perspective, is there a level of trust, if you will, with consumers and these three big tech companies. Would consumers really trust Amazon, Apple or Google to really provide them with let's say a mobile application to direct them to this lowest cost of care? And what we found is at least by ... the key difference here is by age, between the 18 to 44 segment, about three quarters of folks said they would trust them and about half when it's 45 and up. From our standpoint, that's a pretty critical thing. So when you think about Amazon, 100 million Prime members that are out there with the saturation that they have in households, I think they are in something like 60% of households and of those households, they have a further concentration in those households that have higher incomes which again are more commercial plans. You can start to stitch together a little bit and say, that's a pretty scary prospect, if you think about it from Amazon ... what they could do in terms of redirecting care potentially.

Andre Maksimow:

We expanded this question to ask, including the three big tech companies, we expanded the question to ask, let's put in the local health system and the insurance company as well. What would the results then hold there? The headline results are still consistent. What we found a little surprising, frankly, is insurance companies were up there also in terms of online tools, that folks would trust them. Typically, we never thought that the public opinion was that favorable for insurance companies, but never the less, they have more trust. And what's interesting, again, for the clients that we serve most, local hospitals and health systems are on the bottom of this curve right now in terms of that trust level, being able to stand up to online service. These are some of the pressures that are going on.

Andre Maksimow:

Finally, this is our standard provocative slide. Let's picture what could happen. We've put these slides out with a lot of the folks that we talk to and again, it's not out there, this is a complete hypothetical right now, but is it possible or is Amazon thinking about this right now, rolling out a very low cost insurance product where perhaps unlimited virtual care would be provided? Significant discount to the various providers, lost cost premiums. Again, they have over 100 million Prime members in the brand

that they have, and frankly, every one of us uses them every day. Again, we don't have any special knowledge of when this may change or not, but we tend to think that Amazon is probably one of the major disruptors that could really upend the healthcare market.

Andre Maksimow:

We show Apple here as well. Their focus has definitely been on the provider side, but what they are really trying to combat here is the ability to access patient records easily. Right now, very difficult to access your own patient records and even worse so, if you're going to different providers. Let's say you go to one health system, you get all your care there. Then suddenly you're on vacation, wherever the case may be, you're caught somewhere else, the ability to access those records at your other healthcare system, virtually impossible right now. That's got to be done completely on a manual basis. It's got to be actually faxed over right now. That's the latest technology there. What's happening is the administration actually, this is another effort where they are trying to force interoperability between all the electronic medical records among the health systems so that patients actually can benefit and there is this interoperability, that you don't have to change your records over and you're not contained, if you will, with one health system. Now you have more choice, more freedom.

Andre Maksimow:

Finally, to wrap this up in terms of the trends. Why scale matters in healthcare. When we say scale, we talked about some of the companies that are out there. CVS Health, United Healthcare. These are both companies that are about $240 billion in revenue. Huge amount of resources, not only from a financial point of view but the internal talent. The scale of these companies here as well, we talked about CVS, 11,000 stores nationwide and they can make changes very quickly. From our vantage point, what we talked to our health system clients about is that what we're seeing more and more is you've probably seen some of the local hospitals in your area, you might have heard a little bit more about the consolidation that's gone on. One health system takes over one hospital versus the other and traditionally since I've been involved, which is about 10 years, when I first started, acquisitions were all about there is a troubled hospital, there's some sort of financial concern, bad management, something went on. Then there will be another hospital system to save the day. Usually the business case for something like that is you save on synergies, you can drive cost down, better contracting, more efficiencies, more back office efficiencies.

Andre Maksimow:

But really now, a lot of that consolidation has really subsided. Right now a lot of the health systems are out there, they are trying to think about this a little bit more holistically and say okay, if we're facing all these different competitive threats right now, what should we be thinking about a little differently? Probably the areas they are most deficient in is, financial resources, they certainly can cobble together financial resources for what they need, but the areas that are probably, you may not think about all the time, but ... I'm sorry, am I still running? Okay, good.

Andre Maksimow:

The areas that you may not come to mind initially is two elements. One is trying to capture eternal talent and the other one is the ability to attract innovative partners. The one thing health systems still have which is a huge advantage right now and they are trying to monetize it, and they are thinking of different ways to partner with other companies is data. Electronic medical records have been in place for about seven or eight years to a large degree. Huge amounts of data on patients in terms of all the

different episodes of care that have been provided, all the different outcomes, all the different tests, all that information and what's happening right now is, Google is probably one of your better examples. Right now they are working with Ascension, the largest health system in America, and Nationwide Catholic Health System, they are trying to partner with them so that they can take all this treasure trove of data, if you will, and start creating some predictive analytics. And the predictive analytics to help prevent some of those episodes of care or those bad events happening before they actually can occur with artificial intelligence.

Andre Maksimow:

That's really the real gem, if you will, within health systems right now in terms of what they really own and as they are thinking about different mergers and acquisitions, a lot of that is having this larger laboratory, if you will, between the health systems come together and have this larger treasure trove of data so that potentially that could be harvested for some other opportunities. Finally, with all the disruption that's going on and the changes that are happening, reimbursements going down, a lot of these other trends that are impacting them, quite frankly, there's just a real benefit of being larger from the standpoint of being able to withstand some of these major changes that are happening.

Andre Maksimow:

Last, in terms of the M & A, just to give you some perspective, in terms of how many deals go on a year, for the last, let's say five, seven years, about 100 deals occurred each year. And like I mentioned before, when I first started my career with Kauffman Hall in 2010, largely these deals were small community hospitals, some kind of financial trouble went on, another larger system would take over. Now these deals are starting to become much more sophisticated, much more sophisticated parties are starting to come together right now and quite frankly, you're seeing deals that I never thought would occur, which are deals where one health system might be located in Michigan, another health system is located in Ohio and they decide to come together. Clearly there's no benefits from the standpoint of managed care contracting in that kind of consolidation. There's a lot of other strategic reasons that are driving that.

Andre Maksimow:

And what we're also seeing is that for those community hospitals that have not been part of the consolidation wave, the next best alternative now for the community hospital unfortunately is, when M & A is not a solution, then the next step is bankruptcy and liquidation and we think we're going to see a little bit more of that. Right now, heretofore, it's really been happening more in the rural states, those states that don't have Medicaid expansion, they've really been hit hard, but you're going to start to see some additional community hospitals and some of these other systems go under because, quite frankly, all these forces that are at bay right now are really impacting hospitals and health systems.

Andre Maksimow:

With that, now that I've hopefully set the table for folks, I see a lot of yawning and head nodding so, try to perk this up a little bit and not have me drone on, I'm going to love to invite my fellow panelists here and to have a little bit more interactive discussion.

Andre Maksimow:

So maybe to kick it off, Brian.

Brian Cloch:

Great. My name is Brian Clough, I've been in the senior living post-acute care space for about 36 years. I'm currently involved in a few companies. I am owner and operator with some partners of affordable assisted living facilities in Illinois. We have some senior apartments as well. I'm currently developing three new skilled nursing facilities in Illinois, two of them are focused on short term rehab only. The third one has a combination of short term rehab and long term custodial and dementia care. I'm involved in institutional pharmacy business that serves mostly an assisted living population. The final thing that I'm involved in is probably one of the more exciting things is working together with an insurance company called MoreCare out of Chicago that's an IE/IE-SNP plan and working with a provider called Oak Street Health to do enrollment in our assisted living facilities to provide care coordination and primary care. We'll talk a lot about that today, but it's pretty exciting. We went live January 1st and got some interesting results and today we'll talk a little bit more about that.

Andre Maksimow:

Great. Grace.

Grace Chen:

I am Grace Chen. I have been in healthcare for just around 20 years now, always on the care delivery side. I've been in academic specialty medicine, dialysis provider and the last eight years in value-based primary care. I'm the senior vice president of Care Services for Oak Street Health. My role is to think about programs in serving high risk patients outside of the four walls of our centers. Part of my job is thinking about home-based primary care, think about house calls back in the day and then working with Brian on this senior living communities and extending our care into that environment.

Andre Maksimow:

Thanks. Mark.

Mark Feinberg:

Hi. I'm Mark Feinberg, founder and CEO of Stay Smart Care. I've been in healthcare for probably close to 30 years at this point working for companies like Baxter, Allegiance and Cardinal. I started a company called Blue Jay Consulting, sold it to Philips in 2015 and then ran their healthcare transformation services business across North America and then started Stay Smart Care a little more than two years ago. We're an in-home monitoring solution that monitors activity, health and other information to allow people to age in place more successfully.

Andre Maksimow:

Great. Thank you everyone. Maybe just to kind of kick it off and warm us up a little bit, Brian, maybe you should start really quickly with what are some of these trends that are impacting your business or perhaps resonate most with you.

Brian Cloch:

Great, great. We had a panelist that canceled last minute and Ryan, who's a CEO of New Perspectives so he was nice enough to send me some comments, so I'm going to merge my comments and his comments about the different things, but I think when you look at the five healthcare trends we've talked about, the ones that are probably the most meaningful to us in senior living, really are the healthcare disruptors and changes to access. And I think some of the work that we're doing right now is really directly related to that and there has been ... I've been involved in care coordination or primary

care in senior living, post-acute care for a long time and I got some real scars and some wounds that I've had to go through. I owned a company, we managed about 1500 members of Blue Cross/Blue Shield that lived in assisted living and that company failed miserably in the last year, unfortunately, but what you end up seeing is, is just a lack of quality primary care and care coordination services for seniors that live in custodial care.

Brian Cloch:

The real disruption is really around that and what Ryan, if he were here today, what he would talk a lot about in what I think everybody in the room could nod their head and agree, from a senior living perspective, as assisted living, even skilled nursing providers, dementia care providers, we're increasingly getting asked to spend more and more time managing the healthcare needs of our residents. There's no reimbursement for it. There's no, really, knowledge for it, we don't have a lot of quality staff that understand how to manage healthcare services, but everyday more and more vendors are in our building whether it's the pharmacy or it's a home health company or the hospice company or the therapy company, Part A or Part B, podiatrist, anybody else in the building that's in there, trying to get more business out of your residents in the fee for service model.

Brian Cloch:

I think the opportunity to try to solve for that, Ryan's words are that we're having a hard enough time staffing our buildings let alone having to staff inefficient time. How do we get partners to come into our buildings, manage the healthcare, control the healthcare spend issues, get the residents the quality they need while we can stay focused on what we do well, which is really room and board, hospitality services and ADL care. That's what we get paid for. Ryan's words and my words as well, and I think seeing again, combining the healthcare access with the disruption is really a great opportunity. The early results from what we're seeing it was kind of an interesting conversation Grace and I were having before this, as an operator of these buildings, what we're seeing are just fabulous results and Grace will talk about what they are seeing as the provider of the buildings, but we're seeing lots of great things happening that really help us increase the efficiency of our staff, increase the quality of services our residents are getting and just bringing together ... getting out of fee for service, which does not align well with the healthcare needs that our residents have living in a custodial setting.

Brian Cloch:

I think that, that's my answer and Ryan's answer of the two emerging trends that we see a lot of in senior living, is access and delivery as well as disruption in the space.

Andre Maksimow:

So primary care, really aligned primary care coming directly to the senior living facility?

Brian Cloch:

That's right.

Andre Maksimow:

Great. Thanks. Grace.

Grace Chen:

The trends that stand out for me are one, that unsustainable spending is real. The costs are tremendous. There's a lot of waste, I think, that's in the system. And the second is the changes in access and delivery. I think your slides around changes in settings really resonates with me. We look a lot of in-patient setting and hospitalizations and know there can be a lot of ... not all of that is necessary so we should provide the right care for the patients at the right time. That involves coordination. We've got to know the patients, you have to be there as the conditions are changing and direct the care. We believe in that in value-based medicine. When Brian and I were talking, we had a few admissions last week and I was bummed out about it because you think, those are all avoidable. We should be able to avoid the hospitalization, could have gotten a direct admit into a SNF to manage that patient's care instead of putting them in the hospital. A couple of them are still in there, haven't been able to transfer them out yet, so I think there is a lot of opportunity to quarterback for the patient. They also, I think, there's less confusion for them and the caregivers, put them less at risk and then hopefully take some of the waste out of the system.

Andre Maksimow:

Thanks, Grace. Mark.

Mark Feinberg:

So in the same theme of Brian and Grace, I'm going to go with two options as well. Really, the number four potentials for disruptors lurking, I see what we do with Stay Smart Care, monitoring technology to support the care giving that's done in person as a disruptor, but really the need or the demand for that comes from the fact that you have unsustainable spending in our system today. 18% of GDP and growing, as Andre mentioned, what it does is it just crowds out other investment and it crowds out other opportunity for spending on things that would otherwise be for a good functioning society and when you get to a point where you're spending so much on healthcare, it's great for the people who work in healthcare for employment, but as a society, we're not getting ... the United States isn't anywhere near the cost curve. When you look at the cost curve of the developed world and their expenditure for value for healthcare, United States isn't anywhere near the curve.

Mark Feinberg:

So from a labor standpoint, when you look at what we're facing in this industry to care for those people who need support services, we just don't have access to the amount of people to do that work. It's not a luxury to think that we can enhance this and be more efficient in how we drive care for patients by using technology. It is an absolute have to have.

Andre Maksimow:

Great. Thanks, Mark.

Brian Cloch:

I'm sort of dual role here, moderator a little bit with Andre and also panelist, but one of the questions that we have out there is CVS is expanding the Minute Clinic model, primary care model and they are rolling that out, as you pointed out pretty quickly. Chronic disease management and all that that's going on, what are the opportunities to focus on primary care, care coordination, emulate the CVS model into senior living care, into post-acute care. Grace, I'm teeing up to you first, talk a little bit about, I know a little bit more about Oak Street than most, their clinic model, I begged these guys to get in, coming into senior living for seven years and finally broke through to them, but can you talk a little bit more about

the clinic model and how that works and how you believe that is the right model to bring into senior living and what's happening there.

Grace Chen:

Oak Street is an in value-based primary care so we have centers that are built within communities. Most of our communities are underserved, underrepresented from a healthcare standpoint. The idea is where they're in the community so we can see our patients frequently, get to know them often and they can come in not just for clinical activities, but also social, gets us more eyes on them, gets them out and participating within the community, within their care. Our model is also not just the physician and the provider, from a clinical standpoint, it's all of the additive services as well.

Grace Chen:

Behavioral health, tremendous amount of behavioral health needs within a chronically ill population. There are social workers to provide some of the psycho-social support. Frequently the barriers to care are not necessarily the clinical conditions but transportation issues, which we resolve. Pharmacy confusion, we have pharmacy dispensaries that are located within our centers. It can be lack of caregiver support, so we can direct to homemaker services, so surrounding all of these, in addition to the clinical care around the patient.

Brian Cloch:

Talk on that a little bit more, from the early results of what we're seeing in our senior living communities with Oak Street coming to the table with the provider, the payer, MoreCare, what we're hearing from our staff, and it’s only been what, six, seven weeks that we've been doing this, is we're hearing a lot of our staff telling us, "I've got 50, 60% of my day back." They are getting their day back because what's happening is that Oak Street is in our communities with their resources out of their payroll adding to our ability to do better services in our buildings. It starts with the primary care focus where what you really recognize and I did this myself, so I recognize it in my own company that I had before, the lack of really good primary care, their primary care docs will come into the communities and they'll do initial history of a new member and spend 45 minutes to an hour and a half with every member. The doctor they brought onboard was a former doctor that worked in our buildings under a fee for service model and I think his first response was, "I've never spent more than five minutes with a patient. What do you mean, I've got to spend 45."

Brian Cloch:

It just shows you how the fee for service model does not align with what we need for our seniors and our communities. I think, in addition to all that, seeing, having the gate keeper or somebody between all those Medicare healthcare billing companies, home health, hospice, care coordinators, whoever is trying to come into the building having an entity be between that and our staff to sort of understand what needs to get done and they are very incentivized to make sure the residents are getting the care they need but not getting the care they don't need but somebody else wants to bill for. And I think as much as we all want to talk about that, that's a major problem in our communities today with vendors that are coming in and just trying to walk the hallways and get as much volume as they can in our buildings.

Brian Cloch:

I think just that whole opportunity to add other services, and I want to also say, it's really, really hard. You need the commitment of the organization, operationally, in driving enrollment for the residents of the buildings is not easy. Getting people to switch over to a plan and then to a provider, there's a lot of challenges. You need that alignment to make it work. So as you look at the CVS question, I think it's a much different age group and population than what you're talking about in senior living.

Andre Maksimow:

In some respects if you think about in senior living, at least the segue that goes in there, CVS Health, they have a huge Medicare Advantage product obviously with Aetna so are they arguably coming in at the front end so to speak. They are going to have the relationship with Medicare Advantage, with Aetna, on the front end. CVS Health perhaps, in the clinic model, can help these folks and perhaps on the front end, they are going to really start managing that even before they enter into the senior living facility.

Brian Cloch:

And I think that's a great segue. For me, that's exciting because that creates another referral source. Because CVS, if they are going to take the risk and actually take full risk in a Medicare Advantage patient or whatever value-based plan they are going to put them in, at some point they are going to see the value to having that member live in one of our communities where they are going to get better care and services and avoid unnecessary hospitalizations. Grace can speak to that as far as one of the major reasons why I think they've made the decision to finally step into senior living, to stick their toe in the water, and how that works in the clinic population.

Grace Chen:

That's right. I think we see it very much as a continuum. When folks move into the senior living communities and move into this program that we've developed. They come out of our centers so in some ways we are taking business away, perhaps, but really, we see it as a continuum. There's a level of need now that the patient has that puts them into a safe environment where we can extend our care and we have a provider there with our same model, with the same level of support now in that community with eyes on them to kind of catch them in this next level. We'd love to get to, and I think we'll get there soon, into the skilled nursing facilities. That's the next level from supportive living so we see it very much as a continuum as these are chronic conditions. These are patients who are going to get increasingly ill so we need to have all of these elements in place to grow with them.

Grace Chen:

So I think in the CVS model and the Minute Clinics, they are still going to need support as the patients age. [crosstalk 00:47:23]

Andre Maksimow:

To throw in a question here, maybe this is something Mark can address. The referrals could come to senior living, but before they come to senior living, maybe they go to an alternative type of resource whether it be home care or perhaps something else that might be a little bit more cost effective because again, Aetna, Medicare Advantage, they are worried about cost in that equation so they are going to look for the lowest cost alternative first before they investigate anything. So maybe, Mark-

Mark Feinberg:

Yeah, I think if we're starting to talk about Medicare Advantage products with Aetna and CVS and their ability to potentially get into the "senior housing" industry, personally I don't really see them getting into that side of things, it's too complicated. Their business is really with the younger population, but that being said, you hit Medicare at 65 and you're not typically seeing 65 year olds moving into senior housing products these days, they are typically much older than that. There is plenty of runway for them to deal with those types of those patients, those members and the next logical place for them to really engage with them, unfortunately, isn't in a senior housing product, but it's probably at home with a home care product. They are going to be looking for ways to manage that population at home before they move them into the appropriate setting of care and at some point it is the appropriate setting of care for sure, for many people. But the initial take on that is probably not in senior housing.

Brian Cloch:

Mark, how long do you think somebody could, using technology like you have or that's out there, how long is somebody actually going to be able at home safely versus making the choice to moving into senior living, because that's the movement you're seeing happening.

Mark Feinberg:

That's a great question. I don't know the answer truthfully. I mean, I think it's situational for each individual person, but I could see where it would be in the years certainly with the appropriate amount of home care and so at some point you're simply going to need a set of hands, but technology gets to the point where you need fewer hands in order to deliver that care that's needed. So rather than buying four hours of home care and then going to six or eight or 12 or 24/7, maybe you go from four plus technology so that at that point you're simulating 24/7 care in the home and then you can begin to ramp up from there.

Mark Feinberg:

I think as Medicare Advantage plans start to take a look at the value that they are starting to acquire in offering supplemental services of in-home non-medical home care, they are going to start to look at that non-medical in-home care as a technology enhanced version of that so that they are getting more value for the dollars that they spend for that home care plus they get the data that comes out of it that they can analyze and begin to understand from a health outcome standpoint, what's going on with that individual in the home because when the doors are shut, they don't really know. And when they buy home care and they deliver that home care in the home, it's just basic EV visit, electronic visit, verification data. We know the caregiver went there, there's maybe some reporting that came out on what was done for that particular individual, but due to the turnover and the scarcity of resources for labor in that market, the quality of what's going on isn't terribly great.

Grace Chen:

I think the value of having the data is it opens up the conversation over and over again so you can see the progression of it because I don't know the right timing either. I think it's different for each individual, but as you can see the decline or the changes in steps or movement and some of these rhythms that are normally in the home changing, caregivers are then more open to having the conversation of the move, because that's a very tough conversation to have. A lot of folks aren't comfortable with it, but if you have the data to share with them, it makes it a little bit easier.

Andre Maksimow:

And I think that's a perfect point and a perfect segue in that you can use this as a tool to really have a meaningful conversation with a family member to say the data that we're collecting on your family member is suggesting that there is the need to move for additional services or to a higher level of care and from a risk standpoint, it gives you that information that you can then arm yourself to say we've made this recommendation based on the following information that we have for your family member to do the following things and you've refused this so from that standpoint, you begin to arm yourself as opposed to just not having any of this information and being a little bit in the dark when something happens from a liability standpoint in a community that this gives you that to arm yourself.

Brian Cloch:

What's interesting is maybe another question for you, Grace, is that one of the slides that Andre talked about was bending the cost curve. As a country, we have a problem. Rising healthcare costs.

Andre Maksimow:

It's not even on the cost curve. We're not even there.

Brian Cloch:

Maybe speak to how the model of care is doing that because I think most of us have lived through this managed care where its slowing costs by denying care. And the models we're all seeing now, I don't think that's what it's about anymore.

Grace Chen:

Right. There is a shift in that. It very much is coordinating care. We see that now in the communities that we're serving. There is a lot of services that are being thrown at your residents, our patients, that aren't necessarily needed nor do the residents necessarily want them so I think it's important to have someone quarterbacking it to ensure that the services that they do need happen. So we make referrals to specialists and ensure that they actually go to the specialist visit and know the plan following. Often times we're discontinuing a lot of services depending on what specialist we use, if they know us well or not. Sometimes specialists who aren't part of the system aren't necessarily part of value-based care will then generate six or seven additional referrals. I've seen a lot of sleep studies being referred, not necessarily need because what will you do differently with this 87-year old for a sleep study.

Grace Chen:

We discontinued some of those services, it takes the patients into environments that they don't need to be. Getting the right services to the right patients, I think, is a big part of this. Advocating for things like, I was just on a call today around compression socks. It's a DME service that's provided, can't get them, can't get it for the patient and it's working with our payer partner to get the compression socks that will probably keep that patient potentially out of the hospital so it's coordinating all of that.

Brian Cloch:

What's amazing is the senior living company making the decision like a lot of people in this room are either thinking about or starting their own insurance companies or thinking about doing it more, but what our organization talked about was just not negotiating ... what was non-negotiable is the model of care in our communities. How we got that model of care, very open for negotiation and very open for partners. But what we weren't going to do was try to become the healthcare delivery partner to do that. We had a meeting last week in one of our communities with a doctor that had 98% of the ... he's a

primary care doctor for 98% of the patients in two of our communities and we had a conversation about making the movement from fee for service to value-based and we talked about all the benefits we've seen to date that come through that and all he wanted to do was talk about how he could continue to be the fee for service provider in our buildings and that all these additional services that our residents were getting or receiving, that we should just add more staff to our building so that they can get those services. Our staffing was too low.

Brian Cloch:

I [inaudible 00:55:14] that's very nice of you to try to increase my costs while you can increase your revenue and so by the end of the dinner we had, which was nice, I still paid for it but, he sort of understood that it was sort of like this train was on its track and he either had to get on it or he was going to get hit by the train because it was really non-negotiable for us and what really summarized it, the dinner, that really made me feel good about confronting him was he inadvertently made a comment about a lot of our residents in your building, they have UTIs and you guys want us to treat your patients in the building with UTIs. I said, "Yeah, we want you to treat them in the most appropriate setting." He said, "You know, my reimbursement, if I treat them in your building for a visit to treat a UTI or an exam is about $125. If I hospitalize that patient, I get $250." I said, "Yeah, and then I lose my daily rate." So at the end of the day, it's like you can see where there's just not an alignment of interest with what he wants to do versus what we need.

Brian Cloch:

Beyond anything else, what's best for the resident? The resident doesn't want to go to the hospital. What we're seeing, again, early on is that increase of occupancy, not a decrease in cost, but an increase in efficiency of our staff. Now I'm getting calls from executives who said, "I'm getting 60% of my day back." Or clinical directors that are saying, "I have more time in my day." They are managing all this stuff for us. It's just early but it's interesting results so I think what we're finding is that the movement to value-based care in senior living for us is sort of non-negotiable and it's going to be interesting how it happens in finding the right partners.

Andre Maksimow:

I'm sitting in the audience, I'm just picturing myself sitting in the audience right now and saying, "Okay, I own four or five facilities. How do I decide to get involved in this and what's the first step?" What might be really helpful to kind of explain to the audience a little bit is, what's the business glue here if that comes together. I'm a senior housing operator. Do I go out and start hiring primary care doctors and thinking about replicating this model? Do I go out and become an insurance company here as well to create that alignment? If you could kind of explain that a little bit, some of the circumstances that ...

Brian Cloch:

I think it's probably best for Grace to talk about.

Grace Chen:

Maybe you can start with how did you guys start getting involved with-

Brian Cloch:

We started on this journey a long time ago. In our communities, when we started our company in 1999, we opened our first community in 2000, we started with a care coordination strategy in place. We had

preferred providers for all the services for primary care, for pharmacy, and we started with kind of a healthcare delivery. I'm a skilled nursing guy who transitioned into senior living so I approached it maybe the wrong way from a healthcare side that we had to surround these people with healthcare services. So many people started from the hospitality side, real estate side and they wanted nothing to do with it. We have a van, we'll take you to a doctor. We have a van, we'll take you to the pharmacy. We have a van, we'll take you anywhere you want to go. We don't want to touch healthcare. We provide ADL care and food and activities and we don't want to touch that.

Brian Cloch:

I remember in the early days, Mark Schulte, I don't know if he's here, is he in the room, is he even at the conference? But I remember when he was at Brookdale and we had a conversation about doing therapy in Brookdale and he's like, "We don't do that. Residents can choose any therapy company they want, we don't do." And then suddenly he became the owner of the largest therapy and home health company in time so it was kind of crazy. I think it's where you come from. In our company we always did that, but what we realized and even when we did that and we had great preferred providers, we were not getting the results that we wanted. Our journey began a long time ago and we did a lot of things, I failed at most of them, but this one is working and I think what we did is find a good payer that got it.

Brian Cloch:

We had a bad payer, Blue Cross, who was 85% market share in Illinois, but they still didn't get it so that failed and then we found a payer that was really building their benefit plan to meet the needs of this population and then we found a provider that was willing to come in and take on the direct care role.

Grace Chen:

I think the key for us is ultimately getting to full accountability. Full accountability of quality and cost of care. This was our way, on a path there with the right partners where it was primed for us in our back yard of Chicago. I think the value-based piece of it is critical. You've got to have folks who are in that same mindset in order to be thoughtfully directing care and out of the volume business that so many of us in healthcare have been a part of.

Brian Cloch:

Really, the key to success and sustainability on this is having this come together because as a senior living provider, we have a resident that falls in our community, we have to send them out. They fell. We have a liability problem. If we don't do anything, we're going to get sued maybe and we've got to do something. If we're going to enter value-based care program with a provider, we have to work through those things. We can't just automatically be in a defensive position from liability, we've got to work through them and understand how do we get ahead of this. Do we monitor people? We have to have the protection from liability, but it doesn't mean we have to send everybody out. We have to come up with another model and we have to come up with another way to do it.

Brian Cloch:

I think part of it, Mark, to drag him into this fight a little bit, for discussion, the technology piece is huge. We're sitting up here talking about what kind of things can we do to use technology to predict who is going to get sick because as we went down this path, I want to increase occupancy by decreasing discharges, they want to keep people out of the hospital otherwise they have to pay that bill. How do

we keep ahead of that and gather data and information to sort of understand where to allocate resources to who is going to get sick.

Mark Feinberg:

The predictive aspect of this is huge. And as you're able to gather more data in an easier, simpler way the technology that we're using today, four or five years ago other companies, for example, you're probably familiar with the company, Health Sense, not even one quarter of what we're doing at about $250 a month, which is just an unsustainable, nobody really could afford it. Today we're doing a heck of a lot more than that for about $80 a month and so when you think about the predictive element of being able to gather all this data and use it to really understand what might happen in the near future and use that predictive element.

Mark Feinberg:

I'll just go back to that labor piece, when you just don't have enough people to deliver care, the technology piece is the only way to stay ahead of the curve. The benefit of the technology in a predictive way allows you to then take it to a level that didn't even exist a few years ago. In that regard, working with companies like Grace's and getting into senior housing and home care and bringing home care and senior housing together, you end up with a way to bend the cost curve, to deliver value care to the residents in a way that they just haven't had the ability to experience in the past.

Andre Maksimow:

Thanks Mark. Just to kind of pivot this a little bit, following on with the CVS Health-

Brian Cloch:

I think it's your mic that fell.

Grace Chen:

Andre, maybe to get back while you're putting your mic on.

Andre Maksimow:

Go ahead, please.

Grace Chen:

To get back to your original question or your earlier question around how do you get started. To me, we have three players in this. We have a payer partner, we have the communities and the locations and you have a provider. I think if you can connect two out of the three, you can find a third so it's finding someone else who has the same mindset to partner with whether it be the payer or the provider and you can, together find the third.

Brian Cloch:

And I think we all, at least I pick up every morning and read all the different publications that come out, you read all about companies starting their own insurance companies. That's a great decision for some companies that have scale and density and want to do that. That was a really bad decision for us to do that because it's just a different business all together, talk about complexities. It's just a different business. To get a good partner who can do that, that’s great and I think that we want to stay sort of payer

agnostic and really focus on the care delivery model in our communities so we're excited about right now we're aligned with MoreCare as the payer but the future, we see Oak Street being the provider, the value-based provider. Maybe they are going to partner with every MA plan in the market and they are going to be able to convince the MA plans, hey if you have a member that lives in this building, you let us manage it, we'll take the risk and so we might end up having, if they have 100 people in our building and they have 30 with three different payers, we don't care as long as they are on that same value-based care delivery, that's our focus.

Brian Cloch:

We want to stay sort of payer agnostic. Maybe just to throw in here, all this stuff to me, the disruption and all that stuff, somebody wise told me, if you're doing something for less than somebody else is doing for more, you're going to be okay. It doesn't mean it's not going to be easy, but you're going to be okay and the one thing I come back to in this industry, all of us, whether you're assisted living, dementia care, skilled nursing, short term skilled nursing, custodial skilled nursing, we're all doing stuff for a lot less than anybody else can do. There's no way to dissect that and not come back to that answer.

Brian Cloch:

It doesn't mean people with money, I ran into a friend of mine at the airport lounge on Monday, he was a physician, concierge doc, one of the biggest on the north shore of Chicago, flying to Florida to pick up his dad whose caregiver got sick, he had to bring his dad back to Chicago and he said, "next phone call when I get back to Chicago, was calling you and saying what do I do? I've got my dad, he needs something." I said, "You have three choices. One choice is call a private duty home care company and get 24-hour care. It's going to cost you about 5 or $600 a day, but they are going to be legal and they are going to have insurance, they are going to have health insurance, they are going to be paid proper wages. They are going to have workman's comp. You're going to be fine but it's going to be cheap. I did that with my father-in-law, it was $550 a day, 24-hour care. You can hire an illegal citizen who is maybe a nurse in another country, eastern Europe, Philippines, you can pick it, that's going to cost you 2 to $250 a day cash.

Brian Cloch:

They are not insured. They fall in your house, they could sue you. Bad things could happen and you've gotta to find them. They have days off and they get sick and they go on vacation so you have to have a back up plan so I don't know what you're going to do. Or you can move him into an assisted living facility. It's going to cost you for a really good one, $250 or $300 a day and you've got somebody keeping track of everything, imagine. Those are really your three choices."

Andre Maksimow:

I'd love to touch on that a little bit further. Just tying in the concept of the aggregators if you will, the Amazons, the CVS Health, the folks that have all the relationships on the front end, just getting back to that. When you talked about who are the good ones, who are the good facilities, who are the cheaper facilities, that brings up another concept. One of the things that Amazon does, obviously extremely well, is price discovery and transparency is completely out there. So unfortunately, the unfortunate thing is that retailers, unfortunately took some of the disruption from that, but from a consumer standpoint is a wonderful thing. But to kind of tie all these things back here, if you are a CVS Health and you wanted to start thinking about, should I start referring, if you will, because I do have the Medicare Advantage plan,

I do have the relationship, who should I refer to? What does the public really know about what a good senior housing facility is?

Andre Maksimow:

Does that even exist, except for the fact of reputation? Would the industry as a whole be better served to say, you know what, maybe we should come up with something on a standardized basis because for anyone on any kind of institutional level to trust a reputation, that facility happens to be nice or there's good reviews on the internet, that's not going to be enough. Just kind of give us what your thoughts are.

Grace Chen:

We struggle with it too as providers where do we direct, there are so many out there. One of the benefits of this program has been for our own centers that say great, you have a provider in these facilities. We're going to direct our patients, or give them the option of these communities because at least we know there's a provider there that we know and trust. But I would love some sort of rating system or information that's not just cost based, it's also services and quality of care.

Brian Cloch:

It's a huge question. We try to, on the short term skilled nursing side, we try to educate consumers that they have a choice and how to make that choice is huge because you get into these networks and then they get a list and they assume ... I got a list, I got five facilities in the network. My assumption is, the consumer's is, they are all good because the hospital is giving me this list so I'm going to pick the one that's closest to my house. We as a provider who is on that list all the time want to differentiate ourselves because we believe that we are the better solution and we have the data to support that with length of stay, lowest cost for Medicare beneficiary, quality satisfaction surveys from the people that have experienced ... and we provide a different experience. How do we educate people?

Brian Cloch:

We're dying to know. We have no idea. And then you have ... I don't know, it's a huge question.

Andre Maksimow:

If you go into the acute care world in healthcare, the core measures. They started out with 10 and then 30 and I don't even know how many they have now. There are 100s of them. The core measures were very controversial when they first came out and everybody argued, well that doesn't necessarily define good care. Over time they have been widely accepted as really a good benchmark for understanding how we can compare different hospitals and their performance. Things like, if you show up to the emergency department with a particular condition, were you treated a certain way, what is the left without being seen rate at the hospital, their outcomes, a number of different things.

Andre Maksimow:

My suggestion would be quite simply you bring in a number of industry stakeholders who are part of association boards and you convene a group of people who study this and come to the conclusion that we can all agree that this is one good measure or these are 10 good measures that every organization can be measured against and then eventually grow that to be a larger number and then put that out there. Because I think that transparency will ultimately serve the industry well in the long run for sure.

Brian Cloch:

Yeah, I see Bob out here. Brian's here. But maybe you guys want to comment on what do you think the impact of the ability of getting an industry like this together to create a transparent way of measuring and communicating with consumers.

Speaker 5:

I would say it's important to do, but extremely difficult. Senior housing care industry, anytime the issue of standards in any sense is raised, unless we're talking about something different here, is highly controversial [inaudible 01:10:02]and I think part of that is that the legacy of part of our industry still believes they don't do healthcare [inaudible 01:10:10] goes on in their building. So given that, it makes having discussions such as you are having more difficult. So as the industry comes to accept the fact, and not only accept it, but actually embrace it as a good thing, that we are an integrated care delivery center, not that we are necessarily providing all of that healthcare but that it is going on in our building, then when you are there you realize then you need to agree what are the things we're going to measure and what are the outcomes. I think, just to be candid, even the folks here at this conference most of them are here because they are really interested in this and really want to figure out how they'd do it, but that's not all the operators out there [inaudible 01:10:56].

Andre Maksimow:

It's interesting. There's a physician that we do a lot of work with, Mike Wasserman. I'm sure a lot of you know Mike. You have to ask yourself, are you in the care business? What is the business we are in? And if you're in the business of care, is that healthcare ca omponent of what you're doing or not and I think that really needs to be well defined because there is a perception out in the marketplace as you advertise, hey come and move into our community because we're going to take good care of you. You're going to be well cared for. And then, guess what, they are not and then the families are mad and then the lawsuits come. And that's a problem.

Andre Maksimow:

I think that definition needs to be more clearly defined and maybe there are those that are in the care business and those that aren't, but it's not clear and I think you're spot on.

Andre Maksimow:

The way it happened in hospitals to bring that conversation back is that fundamentally, CMS Medicare mandated it. That’s what was the ultimate trigger. There was an absolute mandate. Here's what you do, here's why you're going to do it, because there is frustration. From where I sit, at least, looking at the hospital administrator and then looking at senior housing, I think the industry as a whole is much better off trying to think about this and come up with something on their own before someone else mandates it and it's not going to be a government entity obviously. You're all private pay, but getting back to that example of Amazon and CVS Health. When you have a lot of folks upstream that control a lot of your customers ultimately, those are the folks that can ultimately mandate it and really think through that a little bit.

Brian Cloch:

I think on the skill side, CMS has done that with the star ratings. We all waited around and didn't do it ourselves and then they came out and said here it is, this is the star rating and we all know how screwed up that is. I mean, you see facilities that I'm involved with that are five stars that maybe aren't doing

that great right now and others that are two stars that are doing fabulous, but you've got three years before you can fix it and there's all kinds of complicated processes. I think what drives most of this is going to be Yelp, websites, social media. That's what you're really subject to, if you ever go on and look at how your facilities are being talked about…

Andre Maksimow:

But do you want Yelp and social media to control your future or as an industry do you want to come together and ... Grace, how comfortable are you in choosing Yelp?

Grace Chen:

For restaurants, very, but less so for where I'm going to send my mom.

Brian Cloch:

It's definitely going to be ... I got a call this morning about this, about how do we create consumer awareness about what we do, to educate people that they have choice, how do we distinguish ourselves from everybody else out there and how do you manage ... I mean, other industries do this so we just have to look other places to find these answers, but as senior living healthcare guys, I don't think we're really good at that.

Andre Maksimow:

I'll ask you the next question. What about price transparency? Actually having something where, you brought up the point before that if you do something better than someone else and you do it for half as much, you're bound to be successful.

Brian Cloch:

Yeah. I think we sort of have price transparency. I don't think that there is too many people out here that are afraid of posting their prices or having their prices out there. It's just the competitors that will come in and say, for senior living, private pay senior living, I'm $6000 a month. The guy down the street is nine. What you don't know is we're going to change that based on care levels once you come in. So everybody is playing those games already or are trying to figure out where do they fall in their price. I think it's like checking into this hotel. We checked in, which drives me crazy and now there's some law, if they ever get it passed, you walk in, it's $300 a day, what you thought it was, and oh, there's a $50 a day resort fee. Like, I didn't know about that. It looked like you were the cheapest price online. I think that's the same challenge we have in other places.

Brian Cloch:

I'm not sure that this is an industry that's afraid of transparency. I've never really-

Andre Maksimow:

Do you think it's easy for a consumer to compare one facility to another absent going there and actually feeling, touching, just trying to think of that.

Brian Cloch:

On price, I think it's easy. On the quality and what happens, it's very, very difficult. My mom lives in an assisted living facility. She lived in one, it was run by one company. They were moved out by the real

estate owner and now it's a very different experience than it was. She lived there four years so you know, you don't have a lot of ... you've got to boat with your feet almost. I think these things change and even my own facilities that I own, the right leaders, they are doing great. Somebody resigns, the wrong leader, you've got a challenge. They all go through their peaks and valleys. So it's hard to say what it is.

Brian Cloch:

Any questions?

Speaker 6:

One other comment, if I can, about that care question because I think your comment was spot on and I really hadn't thought about it quite that way before. We've always talked about seniors housing and care and now we're talking about integration or healthcare delivery and chronic disease management and care coordination in our buildings, whoever is doing it. What we have is a very elastic use of the word care and a lack of definition of what we mean by care, which then leaves the consumer either assuming we are going to provide something that we're not or and that leads to concerns as well. So I think it's an excellent point. Senior care has to define what care means.

Speaker 6:

Obviously there were original definitions in terms of activities of daily living and the personal care that's involved, but now when we're talking about healthcare, the word care has different meaning to it and I think, as a sector, we're going to have to figure out how we talk about that. Meaning, not just here but basically with our customer and ultimately that's also going to be with social media, that's going to be with state regulators, all those different areas. We're going to have to really figure out what we mean by that and what we're saying.

Speaker 6:

And as you said, who is in that type of care business. Meaning having integrated care delivery platform where we're really monitoring mom's chronic conditions and so on and so forth versus who is just saying no all we do is assistance with the basic activities of daily living and we don't do anything else. You've got to deal with that separately. You do all that coordination, adult daughter with different doctors and you collect all the tests and you figure out and so forth. So I think you've raised a really good point that does face us as we look at this healthcare/senior care collaboration.

Brian Cloch:

How many organizations define themselves as healthcare from the senior living side, not the skilled side, obviously that's different. Somebody else want to ...

Speaker 7:

[inaudible 01:18:00]

Speaker 7:

You just asked who also considered from the senior living side a part of healthcare and I was just raising my hand, that I did.

Brian Cloch:

You do, okay. Okay. Sorry. Sorry. It's hard. I don't think you have many people ... I think it's changed over the years certainly, but I think you still have a lot of organizations that say we're not in the healthcare business, we're in the senior care business and I think that's a huge challenge.

Speaker 7:

I wanted to add one comment since I have the microphone and that is I think that if we're talking about a free standing assisted living or memory care, that might make a difference in 1.thinking whether or not they provide healthcare because if you have a full level campus and you have skilled nursing on your property with the other levels of care, there's a lot of transitions that can go back and forth and certainly we want to keep people in their lower level of care for as long as possible but at least there is a place for them to go if that isn't going to work and they need either post-acute rehab and go back or out patient from wherever they are, if those services are already being provided on your campus or long term custodial care, meaning skilled.

Brian Cloch:

What our goal is, is the care delivery model, healthcare delivery model, that piece that gets paid for by the insurance company or by Medicare should not change based upon where the resident's living for their custodial care needs. And that's the problem with our system is that right now that changes every time we move. That relationship changes, even for us. I have a concierge doctor. He's not my primary care doctor if I go to the hospital. If I had to go to a SNF or an AL building, he's certainly not my primary care doctor in that setting either. The unique part of what we're trying to do is put that all together so that the Oak Street, the provider, doesn't change. They might be somebody living in an individual apartment going to Oak Street clinic for their primary care, as they age, maybe they get more services at home. As they age, maybe they go to an assisted building where Oak Street has got their model, and as they go to skilled nursing, Oak Street is going to follow that member throughout that continuum. The setting they are in shouldn't matter and that's what the goal has got to be, the north star of what we've got to do, is that healthcare delivery piece shouldn't make a difference of what setting you live in and right now it does.

Andre Maksimow:

But what you're describing is in essence a model where I operate a senior housing facility where we offer senior care but the senior care is being offered by Oak Street, right? I think there are a lot of people in the room and I think to Bob's point is that the industry in general talks about senior care, we offer senior care. And there's, it’s a nomenclature issue, are we senior housing or are we offering care services, are we part of a CCRC with a skilled nursing facility where we have care services on campus or are we a free- standing IL/AL or memory care that doesn't offer that and then has where you go buy senior care. It always amazes me, you talk to people even in industry and you mention the words home care or home health and they screw it up because they just mess up. And a lot of people don't know the difference between non-medical and medical, but as many people who know it, don't know what the difference between home care and home health and I think as an industry, there really needs to be some work done around what is senior care, what is senior housing, what is healthcare, who is doing what, what's the swim lane and explain that to the public because there is a lot of confusion out there to Bob's point.

Andre Maksimow:

And Mark, to your point in terms of, I think we had this discussion before, is if technology is improving and you're able to stay in the home longer and longer, when you extrapolate that out a little it, then you

think about it, the senior care providers, they are not going to be winning customers over on the real estate itself, they are going to be winning on the care component, right, because they are going to be longer and longer in the home. They are going to be out, from a technology standpoint, you can order the Ubers and all those types of things are going to get more and more customized just for seniors so when you really think about the end point for senior care, what are you ultimately really selling them?

Brian Cloch:

I think we're out of time, but for us it's a differentiator. We want people to come to our building and see that we have quality real estate, services on the ADL and we have a great healthcare provider in our building and we have the results, keeping people happy, healthier and longer in our communities, which is our goal.

Andre Maksimow:

Thank you everyone. I think that's it.