What's the Physician's Role in the Value Equation

Anne Tumlinson:

Hi, everybody. Welcome. I'm really excited that you're here. This panel session is on the physician's role in assisted living and nursing homes. My name is Anne Tumlinson. I think we're running a little bit late, but I think there's still some people coming in, so quick turnover between panel sessions this morning.

Anne Tumlinson:

So anyway, thanks for joining us for this discussion. I'm really excited about it. The role of the physician in nursing homes and in assisted living is what we're going to be talking about, and it's an especially important topic right now for a whole variety of reasons, not the least of which is that we're seeing sort of the acuity or the frailty of the population in assisted living and nursing homes increasing over time. I'm going to share some data, if you haven't seen it already, just really quickly that makes that point. And the federal government is kind of aware of the fact that we are now living in a world where we have to pay a lot of attention to how much we're spending on a per-person basis going forward, given the aging of the population and the growth in the over age 80 population. The over age 85 population in particular, that uses a lot of health care.

Anne Tumlinson:

So sort of in that context, the population that is living in senior living and in nursing homes is kind of a prime target, or an important candidate for a lot of the value-based initiatives that the federal government has been experimenting with, and certainly for the growing role of Medicare Advantage in serving this population. And so for those of you who don't know what Medicare Advantage is, it's a private insurance approach. It's an option for Medicare beneficiaries for getting their Medicare benefits through a private insurer. And enrollment in that program has been growing really rapidly.

Anne Tumlinson:

So I think kind of the issue at hand is that we now have this increasingly frail population living in our buildings who are using a lot of health care that is the responsibility of organizations that are kind of part of the marketplace that you're interacting with, so your referral sources and insurers and others are now kind of on the hook for all of the health care that your residents are using. And so there's a growing focus and an emphasis on really managing that population, improving their outcomes, and without question, there is no way that we can do that better without I think really addressing and looking at changing the role of the physician. And in fact, I would even go so far as to say primary care physicians.

Anne Tumlinson:

Whenever we work with organizations specifically to help them think about how to improve the overall wellbeing of their residents and bring health care, integrate health care more into or coordinate health care for the residents, the first thing that we talk about is how we're going to bring sort of the primary care presence on-site, and one that's very integrated and very involved not just in the residents' lives, but in the operations of the building. And so we're super lucky today to have the panelists that we have here. These are probably the four people who understand this better than anybody else, and you're going to learn a lot. So anyway, you guys can see here who our speakers are, but I'll just introduce them kind of going down the row.

Anne Tumlinson:

So we have Jim Lydiard, who is from CareMore and is the director of the CareMore Touch program. And we have Steve Buslovich, who is here from an organization called Patient Pattern, and has a lot of

insights into kind of what the patients look like that we're serving today. We have Dr. Arif Nazir, and Tom Haithcoat. So, welcome to all of you.

Anne Tumlinson:

Let me just very quickly kind of lay the groundwork before we get into our discussion. And I'll give them an opportunity to tell you a little bit more about what they're all doing, too. So the assisted living, I just want to kind of draw your attention to the last two columns on this slide. And in particular the second to bottom row. So the share of the population that has two or more activities of daily living limitations. Two or more activities of daily living limitations is a really high level of need. And you can see that in nursing homes today. Pretty much everybody in a nursing home has a need for assistance with two or more basic activities of daily living. That's a really high level of need.

Anne Tumlinson:

But in the assisted living setting, 63% do. And equally high percentage have cognitive impairment. The independent living setting is a little bit less. You see kind of less full-blown frailty and challenges with activities of daily living, but you see that there's an increase from the kind of residential retirement housing setting of about a doubling of the rate in that initial functional decline and cognitive impairment. So not surprising probably for anybody in here who operates in this space, you've been experiencing this very much in real time, that the population that you're serving is getting increasingly frail, and increasingly in need of services that kind of extend beyond what you may provide in your building.

Anne Tumlinson:

So when we look at how much health care these residents use, we see pretty high rates of hospitalization kind of relative to the just kind of typical population living in private housing. And that's everybody living in private housing, not necessarily a comparable population but just as a point of reference in the overall Medicare population. The rates of hospitalization are about 230 per 1000. At the far other end is the nursing home population where we see rates of hospitalization closer to 700 per 1000, 680 per 1000, which is really pretty high. And then assisted living kind of sits in the middle.

Anne Tumlinson:

Now, one of the things I think is really interesting about the assisted living setting that we're seeing in the data is that the rates of ER use, visits to the emergency room, are about the same in assisted living as they are in nursing homes. And yet, assisted living residents aren't admitted as inpatients as often as the nursing home residents. So what I suspect is happening is that we're seeing a lot of kind of quick staff in an assisted living facility who are kind of quick to call the ambulance, but perhaps not everybody in that group necessarily really needs to be seen in a hospital.

Anne Tumlinson:

And then I have kind of on the far-hand side of the slide some rates of utilization that we've studied among the Juniper community resident population where they've implemented integrated health care and certainly have a nurse practitioner on site. And we're getting much lower rates of utilization in both the hospital and the emergency room setting. And then finally the final point that I'll make just before I turn it over to the panel to tell you a little bit more about themselves and what they do, is that we see Medicare Advantage penetration. So the rate of enrollment in Medicare Advantage plans among residents in assisted living and assisted living is actually 30%, which is very close to the national average.

Now this varies geographically, but I don't know, I was kind of surprised. I expected that rate to be lower. I thought maybe when people kind of get to this point in their life journey and their health care journey, they're using less health care. I mean, they're using more health care. They have a tendency maybe to stay in fee for service or just switch back into fee for service, but that is not the case.

Anne Tumlinson:

We're seeing them enroll in Medicare Advantage at rates very similar to the overall population. So, and again, Medicare Advantage plans are just one example of the entities that are holding risk and responsible for the health care, for paying the bills of all of this expensive hospitalizations and ER use that you saw in this previous slide. And they're covering the residents in your buildings at a rate of about 30%. So these are just some kind of data points I want you to keep in mind as we have our discussion. And I thought we would start off first and foremost to give you all some more context into our discussion to have a little bit of an understanding of what each one of the folks do, and the organizations that they're here representing. So we'll start with you, Jim.

Jim:

Good morning. My name is Jim Lydiard. I'm a staff VP at CareMore. I've been with the program for about 10 years. We're a subsidiary of Anthem, but we do support non-Anthem members alike. At CareMore day in and day out I support their senior living programs that we've coined Touch, and those really comprise our mobile care delivery solution for our seniors, our Medicare Advantage program members, and Medicaid in some markets, that live in assisted livings, nursing homes, or even state by state in some of the smaller board and care or assisted living homes that exist.

Jim:

We've been operating those sorts of mobile care programs since 2007, and had about 7000 members on our portfolio in about 1000 different long term care communities. As far as the physician role in the value equation, CareMore also does support a number of other medical models. We state by state have hospitalist programs, we have transitional care, just short term acute stay or post acute stay programs, hospital at home, and of course, do have brick and mortar care centers for chronic disease management as well.

Anne Tumlinson:

Okay, thank you. Steve?

Steve:

Good morning, everybody. I'm Dr. Steve Buslovich. I'm a geriatrician. Many of you may not know what that is. We particularly care for the frail elder and mostly medically complex, and what I often find that's very interesting is that most of my patients are not chronologically old, they're physiologically old. And so that's always of interest to see how do we tackle this particular problem. So I started a software company to help me assess clinical risk of my patients in my facilities so that I can keep a better perspective of how my patients are trending over time longitudinally as they transition from SNF acute to post acute and assisted living in community settings. I'd like to understand which ones are improving, how they're stabilizing, which ones are declining, and where do I focus.

Steve:

Where do I focus my time as a geriatrician? I can't see 400 patients in my building every single day, so which ones really need my attention? And that is a particular problem that I've always been interested in solving. And now, as the model has really evolved to essentially take on more risk and the integrative medical model becomes much more important for success with all these new shared savings models as well as more integrated care, we really need to play well in the sandbox together with operators, with medical teams, and truly share in that decision making and risk management. And so I manage about six post acute long term care facilities in Western New York, and ultimately am very involved in AMDA nationally, which is The Society of Post Acute and Long Term Care Medicine, really trying to set standards for medical directors to be involved in programs like PDPM. We're sharing models of care and those that'll be coming down the pipeline.

Arif:

Thank you. Good morning, everyone. My name is Dr. Arif Nazir. I'm a geriatrician, like Dr. Buslovich. I wanted to be a nephrologist but got pushed into by default, by some amount of luck many, many years ago, into a rural community where I had to provide geriatric medicine care, and kind of realized I had zero training to do so. I mean, I was just trained in the hospitals to check labs in the morning, pray to God that it was low potassium and low sodium that I could treat, feel like a hero and go home. And I realized that when I entered in a room with the patient's chart this thick, I really had zero ability to do so. And it got me really uncomfortable and started feeling really guilty, so I said, "You know what? I'm going to go back and do a fellowship in geriatrics." And I think that was the best decision.

Arif:

My wife wanted me to be a nephrologist, like it would be cool, but you know, that's a different story. We moved on and I became a geriatrician. But I realize that in geriatrics, for me to be able to have an impact, I just could not sustain a private practice of seeing 40 patients a day. That's what you require to do as a physician in a primary care. So I said, "I'm going to go hide in academics where I can see less patients." But again, that was another very good decision I made, and went to Indiana University and really started learning what holistic medicine is, started learning about SDOH, which is social determinants of health, very sexy term these days.

Arif:

But believe me, our patients have been having SDOH since the advent of medicine. So, it just kind of bothers me and makes me a little bit uneasy that whenever CMS starts focusing on stuff, it becomes fancy and cool. But as a geriatrician, I was practicing some of these very important things and concepts along with holistic care, frailty, SDOH, for all my training, right? So, thank God in the world that there's geriatricians, but unfortunately we only have 6000 geriatricians when we need more than 40,000 in this country. So it's a little mini crisis we have to deal with.

Arif:

And hence, I became part of AMDA, The Society of Post Acute and Long Term Care Medicine, which actually is the only organization which is taking an interest, a very good interest, in making sure that physicians have the abilities of two kinds. Number one, how they can be a better clinician in addressing frailty and functional issues in patients who are frail and need our help in senior care. And number two, how to create leaders in post acute and long term care, so that these leaders can go into the C-suites and help actually with strategy. Anytime you have created models without physicians' ability or practitioners' ability to be in the C-suite, we have always run into problems. We can see that EMR

struggles we have right now in our country were based on the fact that we're not able to pull in physicians as much as we should have.

Arif:

Based on that philosophy I said, "Okay, where I can contribute in terms of a C-suite, so I looked for the most innovative organization I could become part of, and found Signature Health Care really wanting to do a lot of cool stuff like what we heard this morning in the general session from the Presbyterian Homes, what Dan Lindh has done. So we actually are doing a risk assessment at Signature Care for every single resident, assigning care to them so that we can proactively start treating acute issues like frailty, functional comorbidities, so that our nurses do not have to deal with it when something blows up at 2 AM in the morning, when they have no support and patients have to end up in the hospital. So yeah, and I'd love to talk more about it, and really happy to be here.

Anne Tumlinson:

All right.

Tom:

Hello, I'm Tom Haithcoat. I'm the chief operating officer for CareConnect MD. We are a post acute care-centric ACO. How I got here has been somewhat of a hunting expedition. Throughout my career I've been hunting the death of fee for service. I kept hearing about it, but haven't been able to find it. So the first half of my career was spent working with long term care and nursing homes, assisted livings, CCRCs, in trying to improve quality. Trying to keep full buildings. Trying to do what you do on a daily basis. The second half of my career was spent on physician practice management in the fee for service world, covering just buildings and post acute care. And so I kept hearing this, that fee for service was dying, and I wanted to be the one that killed it, and couldn't figure out a way to do it.

Tom:

I couldn't do it on the nursing home side. I couldn't do it in the physician side. Because what people haven't told us about this, oh, there's a bridge from volume to value. Nobody told us how deep or treacherous the waters are between those, or that there's a toll bridge once you actually erect it andget it built up. And so in January of last year, I left the physician practice management side and joined a team to build CareConnect, which was the second long term care-centric ACO in the country. There was a nursing home management company that had got into the ACO that was partnering with physicians and through my various roles around AMDA, I had come to know a lot of the physician practices who wanted to join my hunting party. That wanted to join this crusade to finally not only build the bridge, pay the toll and kill fee for service and be on value.

Tom:

And so that's ultimately what led to the decision to create a physician-led accountable care organization of physicians that spent their careers in nursing homes and that's me, the hunter.

Anne Tumlinson:

Great, yeah. Thank you. Well, I just want to start kind of right there, which is, I want to talk about assisted living in just a second. But I think there's a point, at least for me, maybe of confusion that I've always had which is, I don't really understand, most nursing home organizations or nursing home companies have medical directors, but just on a typical day to day basis in any kind of average nursing

home, what really is the role of a physician today? Or is there even one? I mean, kind of what level of contact or nursing home residents? We see almost entirely among the most frail, probably both functionally frail and medically fragile patients. What role do physicians have today in just a typical building?

Steve:

I can start. So there's quite a variation. Ultimately, the employed physician model is almost nonexistent these days except for some not for profit groups, and it's very rare. The fragmented physician that runs in with the car running is still quite prevalent in fact, and it's becoming more problematic because of the fact that we're taking on more risk. And so, if you're coming in and you're seeing patients on a fee for service sort of mission, then that's okay. But if you're actually there to manage risk and you're on the hook for that population, that model is actually a disaster waiting to happen. And so I think we're all trying to understand, well, how do we play better, or how do we bring care to the bedside where the patient is, instead of transporting patient to a clinic, right?

Steve:

And so I think there are a variety of models out there that are trying to accomplish this task, but I think there's still so much, I'd say, heterogeneity around the hospitals that's still running into the nursing home at night really as a side gig, the community doc that's doing it because there's nobody else in the community that could do it. But they don't really have time, either. And so we're demanding more and more from our physicians. And you know, nurse practitioners are obviously helping fill some of those gaps. And with programs like PDPM, you really need more and more involvement and more and more time with these medical providers and the incentives have not changed.

Steve:

So there's incentive for the building for the physicians to participate, provide better clinical assessments and coding, but it doesn't change my reimbursement on the Part B whatsoever. And I can be putting in very different codes that I would still get paid for on the Part B, but they don't really apply for Part A anymore, and so there's a huge disconnect, and Medicare's done a really good job with making us misalign. And I think that's going to need to change for us, essentially become more partnered and really change the models of care, and what physician, nurse practitioner involvement looks like.

Arif:

Well, I've been on a hunting spree too, myself. Hunting for physicians who don't belong in nursing homes, and there are many. I mean, I would say there's more than 50% physicians who've got no business coming to your buildings, or your assisted living, because they either have a fee for service, or I'm going to do well mindset. And anybody who has to have geriatrics, you know, a role to play in geriatrics, just cannot come up with their own personal agenda anymore to provide care for these patients. It doesn't work that way. I'll tell you that it bothers me so much that my eyes kind of opened up since I took this role as Chief Medical Officer at Signature Health Care where I got an ability to visit many, many facilities and see my CNAs and LPNs really invested in their patients 24/7, regardless of the pay they get, which is like 12, 14 dollars an hour.

Arif:

And every single time you talk to the CNAs, all their focus on the wellbeing of the residents, and I'm just ashamed to say that our physician community just has not been with the same agenda. And again, the

other thing is that I don't blame our physicians. I think they are a byproduct of a very, very disconnected fee for service model, and whatever we expected of them, they're giving us. All you need is a warm body come in to sign some notes, and get you to meet the regulatory compliance. Well, you got that, right?

Arif:

But I do have a little bit more optimistic view of PDPM than Dr. Buslovich here, because I think it is finally, maybe in a very clunky way, pushing us together as a better team, and putting a value on this nursing and physician and medical rehab team coming together for the first time, instead of being focused too much on the minutes and this and that. So I think physician role has finally been put under the microscope. Physicians, I think it was very well said in the general session this morning, is that every physician, somehow thought that they're above average. No, dude, that's not true statistically. You're not above average.

Arif:

We, the physician committee, have created a lot of fuss and noise about us being monitored. We have taken it very personally. So I think it is getting better, you know, that bridge was staff too. It's very hard to cross from volume, volume to value. And it did come with physicians really getting very anxious, paranoid and worried, but I think more and more of them are getting aligned. I'm very excited to report that over the last two years I replaced more than 30% of physicians in our buildings. And they're very, very good physicians out there who really want to be an interdisciplinary part of the team. And the most different roles the physicians have right now to play in my opinion, it's not about technology, it's not about the reimbursement. This is all fads. This is going to settle. This is going to go away. We're like cats following this laser on the wall from CMS.

Arif:

The real role that physicians have to play is to reenergize the team. What is the role of the physician in being there as a mentor? As a coach? As a supporting person? I mean, if you look at the literature, by the way not a whole lot of it. If you have a physician who can support the team, pat them on the back and be there, available for them when they need them. It changes again. On turnover, in the spirit, and the morale. So I think to me, that is the most important role physicians have to play. Of course, to do that role, PDPM will get better, your rates will get better, your turnover will go down, you'll deal with the staffing issues. But that's what at Signature we are working on, is how can we create new platforms where physicians now really become the integral part of the team? Not the leader, not the paternalistic partner, but really an engaged partner, where they also learn from the front line CNAs.

Arif:

So we actually are implementing a crossover company, a program called the Care Model, and this model is required at every month. A physician and the nurse practitioner has to be part of a grand rounding process. Like how hospitals provide medicine. That's how everybody learns. Everybody goes on these rounds, three, four hours. We don't have three, four hours in the nursing home. We say like 30, 40 minutes once a week will at least be a great start.

Arif:

So to me the most important role physicians have to play is to understand their role to really, really, how they can reenergize the whole team, which is under tremendous stress. Burnout right now because of this volume to value transitions. So to me that is the number one role. And again, AMDA actually has

competencies exactly to address that. How can physician become a better communicator? Better leader? Better team player? Unfortunately, we only have 5000 members at this point as opposed to where we should have 50,000. So we need a bigger reach with the help of people over here. It should be a must that physicians you deal with have an absolute certification through AMDA in making sure that they have those competencies.

Anne Tumlinson:

Well, could I just ask you a quick question on that too? You're talking about replacing the physician. In your organization, do you have employed physicians? Do you have a contract with physician groups? Just sort of like logistically, how do you, or is it you also operate an I-SNP, or are you sort of paying them through the I-SNP? I'm just curious sort of how you kind of finance that? Because I think some people worry about, well, how would we ever pay for this?

Arif:

Well, you know, we have been paying for physicians. Nursing homes have been paying for physicians for a while. I mean, we pay them the medical doctor fees. Do we ever get any value out of that is up for grabs. We invest 400,000 a month, something like that, ridiculous number, paying these physicians. We just never really got our ducks in a line to get the value out of it. Now with the PDPM agenda, we have very clear things to tell our physicians, like, "Hey, you need to help out with the team work. You need to help out with the diagnosis." Finally we have the ability to go back and set standards and say, "You know what? I need a return on our investment."

Arif:

So, we're already spending the dollars, right? It's just how we now organize, align, and really set our expectations higher than we have ever had with our physicians.

Anne Tumlinson:

Got it. So you're really talking about just really changing and revamping the role of the medical director in these organizations to take a lot more responsibility for the leadership in the buildings, clinical and sort of staff leadership, which makes a lot of sense.

Arif:

Absolutely.

Anne Tumlinson:

And Tom, in the work that you're doing with CareConnect MD, you're using the ACO platform, for lack of a better term, essentially to kind of finance a bigger presence of physicians. Is that a correct way of-

Tom:

The finance part is a little bit off because there's a downfall of an ACO in that we're always trying to chase our revenue. So our revenue comes from an investment of participating groups, but other than that we have no ongoing funding to build that model until we achieve savings. And so the financing of those alignments can be different. And so what we look to is the fee for service available codes which have been broadened over the past five, six years from CMS, that gives access to a physician coming into a facility that can spend more time with fewer patients, yet still be able to maintain their revenue.

Tom:

And so when we look inside the benchmark of a traditional hospital-based ACO, 60 to 70% of that benchmark of about 10,000 dollars is an average for a hospital-based ACO, and that benchmark just equates to how much money per patient do you have, and then did you generate savings at the end of the year, or did you generate more? And on a hospital-based ACO, about 60 to 70% is their own revenue. And I can assure you today they aren't trying to reduce their own revenue, they're trying to reduce yours in the post acute care space by decreasing lengths of stay in hopes that you generate a higher volume of referrals, which, the ones I worked around very closely, we never saw.

Tom:

And so I think the difference when it comes to the financing of that and the alignments are, I guess I've always said since the day my dad told me he'd give me 5 dollars if I cut the grass. If I follow a dollar bill, I can figure out someone's motivation. And it's pretty easy when you can follow that flow of money. And so on CareConnect's side we are a post acute care-centric ACO. We have the highest benchmark of any ACO in the country, so it's just shy of 35,000, so about three and a half times what a traditional hospital-based patient costs. So if you look at a bell curve of distribution within a hospital, we're really focused on that upper 5%. So I think in the presentation just prior to this you heard that 5% of the population spends 50% of the Medicare dollars. I'm only really concerned about that 5%.

Tom:

And so when I look at the spend inside that 5%, it blows my mind. It is unbelievable the outliers that are inside the outlying population. And so it's following that money. And what we need to figure out is alignment, and how do we align with the SNF long term care operator. We've done a good job of identifying, figuring out who's high performing post acute care physician practices around the country. And in July of 2019 we were a mid-year start, started with 11 physician practices in 7 states, attributed 6800 patients. Coming into 2020 we're now in, we have 31 practices in 14 different states and have attributed 17,000 patients. But we're missing a piece. We're missing conversations with the operators.

Tom:

My model, as it stands today in working directly with the physician, assumes one flawed thinking, that the physician is the weakest link. And it's traditionally not, especially when we're talking when engaging with physicians who are solely focused in this space. And so we're missing this flow of money, it's kind of missing that link of the operator in full engagement to help us build that bridge, and that's going to be the financing mechanism. But certainly programs like PDPM are assisting us in that alignment, because now if we get really good at coding, that's going to be beneficial to us.

Anne Tumlinson:

Got it, okay. So before we continue along talking about nursing homes, and we've got a lot of great perspectives here, I really want to take a moment. Jim you're the lone assisted living person here on our panel, but you guys can obviously weigh in on this as well. It's kind of a funny question to even ask. What's been the role of the physician in assisted living? Because there really hasn't, I mean if you look kind of generally across all, if you look at it in a very big picture, like all the assisted living facilities in the country. There's been a very minimal physician presence. Obviously you've been working to bring physicians and nurse practitioners and primary care kind of capabilities into assisted living for a very long time. So you've been doing this for a while. But just from your perspective, what do you see out there in terms of the gaps, I guess?

Jim:

Yeah, great question. And I'll actually say that many of the same theories apply. And in fact I know CareConnect does a great amount of work in assisted livings as well. But your data shows what I think the audience likely already knows, and that is that the residents in assisted livings look far more similar to that of the resident in the nursing home. And what you also know is that this staff, the clinical makeup of the assisted living, is vastly different.

Jim:

So in many ways I think that the assisted livings rely heavier on a dedicated physician partner, physician coverage team. Both for nursing homes and for assisted livings, I think one thing that my personal opinion that I've noticed over supporting these sorts of communities over the last 13 years is, there's an inclusionary mindset that assisted livings and long term care operators have, which is I need to be able to say I work with everyone. It's almost like I don't want to turn away business that could potentially come at me by saying I don't work with this health system, or I don't work with this doctor. And because of that, it might in many ways I think, I believe it doesn't help you as much on the front end as you think it does in terms of move-ins.

Jim:

But I actually think it hurts you in terms of the long run on the ways in which your staff has to react and respond when urgent things arise for your population. So if I was an assisted living operator I would be looking at the role of the physician in a few different ways. Number one, and this was said on the last panel. Would I trust this physician that was recommended to me or that my mom's still using in an assisted living to trust and care for my mother? So pressure test it first with quality.

Jim:

The second thing is, assisted livings and nursing homes, when they need something, they need it now. And they often need it in which to prevent an avoidable hospitalization. So is my physician partner, my clinical partner, going to complement me in keeping this patient happy, healthy, and in their home? And then the third thing is, is there an altruistic partnership? Is there a way in which that I'm rendering value back to this assisted living in the same way that the assisted living is rendering value to me? Maybe in terms of referrals, maybe in terms of growth, maybe in terms of economies of scale, what have you.

Jim:

And I think that if you're an assisted living operator or a nursing home operator, and you can't successfully check all three of those boxes, then you need to go through a sort of reality check that you're not putting your community in the position to succeed medically, clinically, in the way that you could.

Anne Tumlinson:

All right. And too, that's a really good I think kind of transition to, I want to talk about both kind of the imperative to change the way that we integrate sort of physicians into the kind of day to day operations of buildings. So the imperative, but also the opportunity. So like this is kind of, I guess, I would say on the one hand, we're getting to a point where if you don't have a strategy, you don't have an approach that is really very thoughtful about the role of the physician in your building whether it's assisted living or a nursing home, you're going to be kind of behind in terms of where the needs of your patient

population going forward. And certainly the needs of your referral sources and the needs of the payers, and it's just we're getting to a point now where it's kind of essential.

Anne Tumlinson:

But also there's a lot of benefits kind of immediately. And you talked about some of them with kind of the staff retention, the morale in the building, the ability to get, they can deliver better care because they have access to that physician right away. And so presumably you could see improvement in your quality measures.

Jim:

Absolutely, so-

Anne Tumlinson:

And your referrals, and things like that. So I'd love to just, let's just kind of talk about what you have been seeing as the benefits to the organizations that you've been working with.

Arif:

Yeah, so, at Signature Health Care we're actually totally turning the game upside down. I mean, we are creating a science out of physician engagement. We are actually taking every single piece of physician involvement to a very formal level. So let me give you an example. Mostly in traditional nursing homes or assisted livings probably even, we have a few assisted livings also, a decision around medical directives made by a doctor walking into the building, like saying, "Hey, I work at this amazing hospital. I'm a hospitalist there. I'm going to be giving you a lot of patients. You better hire me." And you know, if there's an opening, that's a really great case that doctor has made.

Arif:

That is how traditionally these decisions are made. I'm of course trying to oversimplify here. But we are actually turning it around. We are actually at Signature Health Care creating a whole dialogue around what is a strategy that a building has to have in context of what value-based system exists in that market? What hospitals needs are? We have an analytics team looking at, is there a heart failure issue? A COPD issue in the market for the hospital? What are the pain points of the hospital?

Arif:

Then we go to definitive health care. We look at all the physician presence in the market and look at their strengths and their billings and their experiences. Then we call our business partner team. They look at the list, they narrow down the list, then we interview the physicians. And we try to scare them off. That's what I do. I've done like, "Hey, this is not the 1990s. You're not going to go and come in first of every month and pick up a check under the rug and leave. That's not what this is about. You're going to really work hard for those 2500 dollars we'll pay you, and you will give us an absolute significant detail of every single minute we paid you for that." Because OIG, by the way, is targeting physician payments hugely right now. So, if you have a physician relationship which is quite loose, where you just give them a stipend, and because they bring a lot of patients for you, whatever, that time is gone, because OIG is very clearly monitoring that.

Arif:

To help with that issue we actually have created an app at Signature Health Care where physicians have to report exactly what administrative roles are they doing, and it's based on AMDA's tasks. AMDA wants to do this 15-20 tasks to be a successful medical doctor. Well, tell me exactly what tasks you did so at any given moment as a Chief Medical Officer I have exact detail of what physicians are doing in that role. And they're actually required to do something. They're required to give us a proactive evaluation of the building. Now every medical director has to give us every quarterly a good overview of the medical services affairs of the building they work in. Do you think that's important? That's hugely important. Because if you don't get that feedback proactively, well, these same doctors go and badmouth your building, the hospital. They do, unfortunately.

Arif:

So we're like, "No, no, no, don't talk about those things over there. Give us proactive information, and we will use your information." And then we also have them in our strategy room now. Every one of our buildings every quarterly has to do a facilitate advisory board meeting where the next three or six months are decided on what are going to be the main initiatives and quality improvements. So we now involve physicians into that conversation. So we're really formalizing. Every single physician now, every medical director in our building now gets a very comprehensive dashboard every month.

Arif:

We're not talking about medical records, like your reports 18 months after the fact. We're actually telling them how many pills were being prescribed in your building? What is the antipsychotic rate? How many antibiotics? How many bad medicines? How many polypharmacies? What's the average medications in your building? Every month. And what is the expense on labs in your building, as opposed to the whole company, as opposed to the nation? So we're actually giving them all details on that.

Arif:

And then we don't stop there. We actually go say, "You know what? You're weak on this side. Let's talk about some education." So we're giving them regular education. We have quarterly webinars now with them. We actually pay for their AMDA membership now so that they can learn. Because, you know, if you look at the framework of engagement, it is not just giving people money. That is just a basic requirement you have to hit. The real engagement game starts after that. Once you have convinced people that you're fair, after that is where the engagement comes in. Salary is just fairness. I mean, if you don't give them the right salary, they're never going to be really on your side. So you have to pay them fairly, and then you set up a structure of mastery, autonomy and purpose.

Arif:

Your purpose has to be aligned with them. It has to be a noble purpose. You have to give them autonomy. Don't get too annoying. Give them some room. Let them do their magic. And mastery. Clearly show them an opportunity how their working with the organization will get better every day. If you make those check marks, they'll really become very loyal to you in terms of that. So it's not easy. I mean, as you said, you're just randomly hiring a physician and hoping everything's going to be great, it doesn't work that way. You really have, on your end, to set up a lot of structures.

Arif:

I'm a little bit less upset with my physician community than I used to be, because I've realized that the problem does not lie with these doctors. They're not bad people. It's just the environment just never asked them, never told them what to do, and there were just not any resources to help them out. So I think with the society now with the AMDA and all that we're doing, and with the value-based models with the PDPM, we finally are engaging in a conversation that what should be the role of physicians and really helping us to get to the better health care.

Anne Tumlinson:

Well, you know, I think this is a good segue to some data that you have. So how do we give physicians the feedback, right? How do you give them the information that they need to do a better job inside the organization? Would this be a good time to, yeah.

Steve:

Yeah, I'd be happy to share.

Anne Tumlinson:

So because I think having, it may be just as a quick preface to that, one of the biggest challenges for any primary care practitioner or physician is kind of understanding where the risk is in the building if you're in there on a day to day basis. And so, this is a lot of the work that you've been doing.

Steve:

Sure. I'm happy to share. I think, just to sort of segue, most medical directors want data, and we provide them with almost nothing in a structured way. And I think what Arif's doing is extremely innovative and forward. What I used to do is go to my quality meetings as a medical director and look at my administrator and say, "How are we doing?" And they would like at me and say, "Well, here's our Kasper report from six months ago." And I would say, "Okay, well, where's the problem now? And where in the building is that problem, and how are we doing?"

Steve:

And so they really couldn't give me any information. And so how can I manage an underperforming building with a medically complex population that everybody's paying attention to? The insurers are paying attention to. The hospitals are paying attention to. Families are increasingly looking at our publicly reported data. And yet, we internally struggle to even give our own clinicians information. What data do you share with your nurse managers on a unit level? Zero. They don't even understand the quality measures that are publicly available.

Steve:

And the idea is, you want to have a team effort looking at data that's clinically sound. And if you think about what's happening in terms of the data that we're using today to assess for risk, it's an actuarial exercise. We're looking at length of stay, maybe readmission rates, maybe quality measures. That's already six months to two years old. And so that really doesn't tell you what kind of risk you have in your building today, and where's that risk concentrated? Where should you allocate your resources and focus? Because whether you're in assisted living or a nursing home or an I-SNP, you have absolutely no control over which patients come into your building. You have no control as an organization. And so all of a sudden you're assuming risk for a patient that's coming in with a discharge summary that gives you 10 diagnoses, all of which do not tell you the level of complexity this patient truly has.

Steve:

Somebody with diabetes looks very different from somebody else with diabetes. And so our patients don't have one diagnosis. They have 10. They have 20. And so how do we manage complexity? How do we tell who these patients are when they all look the same from just looking at ISD 10 codes and diagnoses? And so, what we've built is essentially a way to assess for clinical risk using a concept called frailty, which is a mathematical index that's internationally used extensively in Canada, in the U.K., it's actually mandated for every patient over the age of 65 to be assessed for frailty. Why? Because they care about outcomes, and they want to understand clinical risk.

Steve:

Now this isn't data that essentially looks at ISD 10 codes, age, or sex of an individual. This looks at your functional, physiological conditions. And so we look at about 70 different variables, half of which are function, a third cognition, a third of psychosocial. And those metrics actually comprise a frailty index. What we're looking at from a frailty index perspective is actually being able to understand in an objective way who are we dealing with, and what is their likelihood to have a decline? And so we're looking at all these different domains that we sort of color-coded to see what's wrong with this patient today based on today's data, and where should I be paying attention to?

Steve:

In this particular patient, we have a decline in the functional domains. You know, mood's a problem. Incontinence is an issue. And that's causing this patient to be physiologically old. In this particular patient here, if you look at the red dot there, and the blue line represents normal international frailty on a community level for healthy, considerable aging adults. What we're measuring is how fast have you accumulated those deficits compared to everybody else in your building and in the population as a whole? So you could have a comparative view of your true risk, of your clinical risk, which is highly predictive for not only mortality, but every single quality outcome you're looking at including hospitalizations, high utilizations.

Steve:

And so as your patients become more frail, we can actually predict length of stay. We can predict cost utilization. And if you can predict that, you don't have to wait to react to data that's already six months old. You can act on it today to come up with a team effort to try to actually reduce some of that risk, and looking at somebody over a longitudinal time frame. Because it's really not about looking at their risk today, it's where were they six weeks ago? Six months ago? And where have they come? And so what we're trying to do with frailty is really tell a story. Tell a story about a patient, where they started when they came in, did your team, did your approach work? Did they improve? Did their risk level decline? Or did it stabilize? Or are they actually continuing to decline? And so, how does your documentation and your clinical efforts support that change of condition? Are you documenting things like unavoidability? Are you meeting with families? Are you conveying that risk?

Steve:

And so when we look at quality measures, and that screen on the right shows you the quality measures of this patient's treatment for over two different quarters, on the left you'll have clinical granularity to look at the specific clinical areas that your team should be paying attention to, and that's what's going to reduce their risk. And so ultimately when you can convey this information as a team, you can communicate better to family. And that single number one greatest contributor to utilization and cost

are not just frail patients, it's frail patients that have unrealistic expectations. And that's what we're seeing. So if you have a successful I-SNP, D-SNP, and they're frail and you manage them well and you manage that expectation, you're actually going to be very successful. But if you can't manage that communication with the family to align those expectations with their level of risk, they're going to think that their 65-year-old mother is 65, when physiologically she's about 103.

Steve:

And so what do you expect for somebody that's 65 that is very different than you would expect from somebody that's truly 103. And frailty allows us to have that language to essentially communicate that risk, and that's really the biggest opportunity. These patients are coming from the hospital, and they're given misinformation that now we as a nursing home or assisted living have to essentially realign. And that's very difficult to do, because all they got in the hospital is, the stent's working, the cardiologist said everything looked great, you know, mom's going to go home in a few days and ultimately, when we look at mom, she's about five minutes away from hospice, let alone going home. And so now it's our job, it's our burden, which is very difficult to manage those levels of expectations. And so we need better ways to communicate with patients, with families.

Steve:

And assisted livings, while they're managing the same level of risk or very similar, have zero data. They have nothing at all. And so we really need to come up with ways to work together to help manage those expectations, because those are your lawsuits, those are your costs, and that's your census. And this is all, I think, how everything is interrelated.

Anne Tumlinson:

Yeah, absolutely true. I think that the information is really important, and you used a phrase that I think is a good next topic of conversation, which is around changing condition. So I just brought the hospitalization rates back up because changing condition is what is sort of the thing you want to get ahead of, or address as soon as possible in order to prevent somebody from going to the hospital. And in every kind of model of care that you write for any special needs plan, a lot of what you're doing is explaining to CMS what the care model is, what the processes of delivering care inside, you know, physician-led care inside that building are, in order to address change in condition to prevent hospitalization. So I was going to ask Jim and Tom in particular to talk a little bit about what those kind of component parts of, as you're working with physicians around the ACO and interacting with these nursing homes, and as you're working with assisted living facilities and facilities in general, kind of what are the critically important and key parts of the model care or care model, let's just call it care model in this context? And of course, any other reactions that you have to the data and information that Steve just presented. So we'll start with you.

Jim:

Sure. So, first of all, the data Steve presented is incredible. Most population health tools are as reactive as Steve described. I think one other thing that Arif mentioned about where they're going with KPIs and expectations and training, it sounds so right. I think that when I sat back and listened to both of these, I think that while you both had it figured out in your neck of the woods, it's not the norm. And that's what we're here to discuss, is how different from the norm things could potentially be in your community, or in your market, or as a payer for many of the SNFs that I coordinate care with on a daily basis. And let's

also remember that while we've come a long way in long term care and physician components within long term care, house calls and nursing homes is not the sexiest work out there.

Tom:

I beg to differ.

Jim:

It's come a long way, but I think that this is hard work, is kind of what I'm getting at. And yes, there's some great science to it, and yes, there's some great people management that's coming around, but these are incredibly sick folks which is why the government funds us in the way that they do, to take care of these sick folks. Which is why the buildings so need the medical expertise and the data expertise in which to deliver on the plan or the payer's commitment to Medicare and to the government, and of course to the resident. We can't forget that there's a patient at the center of all this, and I'm so happy that you touched upon expectation. Our Chief Medical Officer, Dr. Garg, says that if he were to have to pick one goal that everybody should align on, or one metric that everybody should align on, it's the metric of trust.

Jim:

Trust you have with a patient actually is far better than any other data point that he's ever been able to point to on generating an outcome. I would say that with changes in condition whether it's predictive or whether it's not predictive and it happens, because these are sick folks, what it boils down to is our ability to work cohesively with a community. Does that community know the resident well enough in which to identify the change in condition, communicate effectively with the prescriber that can actually do something in which to make instantaneous treatment pathways? Is there an ancillary wrap-around to all of this, where if it requires radiology or pharmacology or a lab, is there a right ancillary network in place in which to get instantaneous results to guide a treatment path? Or, does the clinical team have empirical permissions to be able to start treating effectively while they await for orders and things like that?

Jim:

And then, are you working with a payer in your system that's set up from a benefit level correctly in which to respond and keep that patient in home? Clear example is most Medicare Advantage plans now don't require a three-day hospitalization in which to skill a patient. So, as Anne's great data and research pointed out in the first slide, around 80% of the long term care population in a nursing home is on a Medicare Advantage plan. But are we using those benefits in the way they were designed? So I'll package that all up to say, communication, communication, communication. Working with available and accessible prescribers that are invested in keeping this patient in-house, and working with the right MA platform that's able to quickly turn on Part A, Part B authorizations to allow the building to safely keep the member in-house, would be some of the change in condition tips that work really well. And for I-SNPs that are working really well, the outcomes are there, and for I-SNPs that aren't, it's clear to see why.

Anne Tumlinson:

Yeah, exactly. Love to have your thoughts on all of these things.

Tom:

Yeah, that's an awful lot. A lot to take in, and Anne, you know, so my feedback on that's going to be, what are we doing with engagement with a care model within the physicians participating within our ACO? And it's been a challenge because of just simply the lack of resources and the financing of how an ACO gets funded versus programs like an I-SNP that have payments that are coming in to be able to fund different mechanisms. So within our population, and so we had 600-800 patients attributed to us within 2019, but that quickly moved to 17,000 by the time we got into January first. And so we carved that up and we've got more hands-on funded care model deployment with nurse practitioners and case managers on a very small population of patients that make up that 17,000, to see maybe the entire ACO breaks even. But this pilot model did really well where there's heavy engagement, frequent contact with patients and family, incorporation within the facility. Does that show benefit? Does that show traction?

Tom:

The one overarching that we're doing is the technology and utilizing data to get to the hands of the provider to see if data alone can influence behavior. Will that be able to be enough, whether it's comparative to other providers in their market, in their region, across the country, or is it just their motivation to do things? And we have access in training and education around utilization of new primary care codes. I had said early in this that a hospital benchmark is about 10,000 dollars and 60 to 70% of that is their own revenue. But we have a 35,000 dollar benchmark, and only about 5% of that is primary care revenue, and only about 2% of that is the primary care doctor in the nursing home.

Tom:

So it gives us a 98% opportunity to save. I would much rather increase that revenue stream from 2-5% to 7-10% and be able to have more funding at bedside and be able to gain share with facilities or be able to do something, but it sounds counterintuitive to want to increase revenue and increase savings, but it's exactly what we're trying to do. And it's through that data, can we drive behavior change? And it's through incorporation of new billing codes that allow for more frequent, more ongoing interaction, and it allows a physician that can go into bedside, spend an hour avoiding a hospitalization. In today's environment they get paid 65-70 dollars for that arrangement. But it may have generated someone savings of 30,000 dollars by avoiding that.

Tom:

And this allows both a facility as well as a physician to tap into that 30,000 dollar savings than the 70 dollars and a thank you for avoiding a hospitalization.

Anne Tumlinson:

So I have a couple last questions for the panel, and then I want to just be thinking about any questions that you all may have, because we'll open it up in just a minute.

Arif:

Can I just comment?

Anne Tumlinson:

Oh yes, please, yeah.

Arif:

Just one more thing. The very important thing which you mentioned is how to invest in quality. I just want to highlight to one important issue here is that we just cannot underestimate the value of geriatric education and training. I mean, we are such under-resourced in true geriatrically trained workforce that it kind of bothers me. It's one thing that makes me kind of like really, really worried and concerned, like how are we going to resolve all these problems? Again, as I said, we are significantly short in geriatricians. We are way short in frontline nurses who understand geriatrics. So anything as health care leaders we can do to set up structures for education training, we should be investing ourselves into.

Arif:

It's a responsibility we have. This is something we need to give back to our community, to our country. I'll tell you that as a physician leader myself, I have to deal with this fake quality, which is very important for my reimbursements, which I call the fake qualities, the [inaudible 00:58:57]. I mean, did the 89-year-old patient with dementia, pneumonia and 16 admissions is on a cholesterol pill? Is that really important? Yes, it is. Somebody gets paid. You know, so it bothers me that since we have gone into this volume to value based transition, the number one investment, or the top few investment has been in IT companies. Nothing against, patient pattern, but there have been companies out there which have not been guided by physicians or medical teams, but they actually help large organization look like excellent companies. I mean, using loopholes, using data, and all that. Nothing wrong in that.

Arif:

There's was a paper published in JAMA, which is one of the most credible journals six to nine months ago which showed that companies which were richer were able to look like superstars by investing in those systems. Mom and Pops who don't have the ability to invest in the system will never look like superstar, will never be able to get more out of these [inaudible 00:59:51] systems. So there is one quality which we have to meet to get reimbursed and all that. That's fine. I get it. But really understanding your organization, what does quality really mean? It could be patient satisfaction, it could be some process which is important to that family. Be very, very clear in every single patient interaction. What does quality mean to them, and do your best to hit that. And the only way to hit that is making sure that you have the highest, highly trained, geriatrically trained team with you. It's not about IT, it's not about technology, it's not about the shiny object there. It's really about understanding, taking the time and having that empathetic team who is really committed to that interdisciplinary geriatric work that you need to do.

Arif:

But I just always want to highlight that, that if you have good five star rating, you may or may not be high quality. If you have physicians working with you who are really great on Macro but [inaudible 01:00:41], are maybe not the best physicians, right? So make sure that in your exploration, in your understanding of quality, you do pay attention to it. What does true quality mean in your organization? And you need to hit those marks.

Anne Tumlinson:

Thank you. So before I ask my last question, I do want to just pause for a moment and see if there are any questions from the audience. Oh, great. We have one back here. So we're going to ask you-

speaker 6:

[inaudible 01:01:02]

Anne Tumlinson:

Oh, okay.

speaker 6:

[inaudible 01:01:07] reference to the technology and software development, [inaudible 01:01:20] So, where does artificial intelligence, machine learning, and all this wearable technology, some of you, you talked about scale quite a bit. And that's why I'm curious what United Health or Humana or some of these big operators are doing as far as kind of original? Either original development or testing. You know, early adoption of some of these groundbreaking technologies.

Arif:

The only thing I'm going to say to that is, because that's my favorite question and I've got a great answer for that. Nobody should be allowed to touch artificial intelligence before they're using their natural intelligence well. And in our health care systems, we're not even using our natural intelligence well.

Anne Tumlinson:

I'm using that.

Arif:

So just be careful with that.

Anne Tumlinson:

I'm totally going to use that.

Tom:

Stole it. That's a good one.

Steve:

My opinion on that is, I don't think that's real. It's a real term, and I agree with Arif, naturally we need to distinguish statistically significant data from clinically significant data. And those two things are not the same.

Anne Tumlinson:

They are not.

Steve:

So, just because there's a correlation with patients that have coronary artery disease that need a cholesterol medication, if you put that frail patient on the cholesterol medication, they're going to have very bad outcomes. And so ultimately it's easier for big data to come up with new correlations or suggestions, but they can actually harm our patients that are quite vulnerable, and that's typically our frail populations. They're not looking at that because they don't have that kind of clinical data. They have labs, ICD 10 codes, HCC codes. It doesn't tell the story. So just be careful what kind of data all these AI platforms are actually using, and often it's not clinical data that's reliable.

Anne Tumlinson:

Any thoughts about the question about sort of how the payers are looking at technology in this space? I don't know if you have any perspectives from Anthem?

Jim:

And again, I think to your question and the absolutely right answers that I would agree with up here, was a very, I would say, long term care nursing home narrowed answer. I think many payers are absolutely interested in wearables and artificial intelligence, and some of the other digital health tools that exist both from patient identification purposes. There's Medicare Advantage plans out there that are growing leaps and bounds because they're offering Apple watches. I mean, there's a growth answer to this. I think that we're focused mostly on our digital health tools, our things that allow our prescribers more intimate access into what's going on and how to respond quicker.

Jim:

So it might not be as buzzword-worthy as some of the things that you spoke to, but they're things that can actually be incorporated quickly into practice and can save a hospitalization. The big payers out there that are throwing out Apple watches and talking about it, I think are really talking about it not for the patient population that we're most specifically seeing, but more for that 65-year-old that still is very active and golfs and drives, and all these other things, which there's a huge population of.

Anne Tumlinson:

So, any other questions? We only have two minutes left. So this is kind of I guess, what do you call it, a flash question? But just very quickly, you guys just have a wealth of information and I think are very inspiring, actually, about what's possible and just what we could potentially improve in these settings. But so often we hear from operators, particularly in seniors housing and senior living, it's sort of like, this isn't what I do. This isn't my problem. I don't need to worry about this. I don't need to care about this. And in fact, I guess, I would even just say I think there's a disconnect between what they think they do, and what probably the residents need in terms of this sort of coordination and integration of primary care in particular.

Anne Tumlinson:

So, what's your pitch? Like, how do you convince them that this is really important for them to be doing, working better with you, changing their culture? Like everything that you have to do, how do we motivate this sector to get on board with many of the things that you're talking about? So we'll just go straight down, and you get to go first.

Jim:

Yeah, I think this conference we've heard a lot about really incredibly innovative things in this setting that we all so much love and support. My quick answer is, just focus on the patient. There's a patient under all this. It's a parent of mine, it's a grandparent of yours maybe. And it's okay to be an operator that has an opinion. And it's okay to point your residents, your patients, down a path of working with providers that work well in your community, generate great outcomes. In fact, many residents move into your settings because they do want your opinion and they value it. So focus less on being inclusive. Focus less on allowing that doctor in that just likes to come by on their way home from work andthey're doing this off the side of their desk, and focus on developing partnerships with truly people thatare

inspired to work and treat your loved ones. Because this is such an important space that we're committed to serving.

Anne Tumlinson:

Great. Thank you.

Steve:

I would just add that we've always been focused on the revenue side in this market, and now we need to understand the cost side. Because if you can't manage those costs, you're not going to be a successful operator in the near future, and with all these new payment models. And the only way to control cost is to have an integrated medical model. Because only your medical team can really drive true cost-effective care that then saves the organization. And so I think that's really where we're at, and why we're all here.

Arif:

I would just say, and that's the message I give to my doctors and my nurse practitioners, so like don't be annoyed when you have to document. Document with heart. There's a reason to document, just to get paid, and there's document to sleep well at night. So I would say, business should not be all about living well, it should also be about how well you can sleep at night. And you can't do that without your customers being satisfied, and your patients, and you providing the best health care to them where they are. I think it's a responsibility we all have. And finally, it's all aligned with payments too, so let's just enjoy this amazing time we are in.

Tom:

And my recommendation is that fee for service is dying. Value is going to be the only sustainable way for Medicare to continue to fund different programs. My recommendation to operators is, make sure you're part of the savings. Don't rely on volume to supplement someone else's value because it's not going to work.

Anne Tumlinson:

I feel like we should put that on a big poster. Because I love that. That was a great quote.

Tom:

And that's my biggest suggestion to operators in this space, is to make sure that you have the ability to access the savings dollar, and not just the front end fee for service dollar. And don't fall for someone promising volume to create their value. It doesn't work.

Anne Tumlinson:

That does not work. That was great. I got so many good quotes from this panel I'm going to use over and over again. Any other questions? We have literally a minute left on the clock. Oh, great.

Speaker 7:

Yeah, I'm wondering if single payer might be a way to get around some of these roadblocks that you've talked about?

Tom:

Too political.

Anne Tumlinson:

You mean like Medicare for all?

Tom:

Now way too political.

Anne Tumlinson:

Sorry, what? It's impossible to know. I mean, it's just not well-formed enough.

Tom:

It's one of many things. It sounds appealing because of its ease. And I just don't know if as a society we're ready for it.

Speaker 7:

Well, I was struck by the frailty tool that everybody was so enthusiastic about. That's coming out of Canada and the U.K., where they do have single payer.

Tom:

I think there would be more significance in one data than one payer. And having a patient own their data than it being locked up underneath a brand in a silo and charging money to get access to it. That, I think, would carry more significance than where the dollar of funding services go.

Steve:

I agree with that, yeah.

Jim:

I think everybody agreed that instead of maybe Medicare for all, we'll just say value-based for all.

Tom:

Value for all.

Jim:

Do away with fee for service.

Anne Tumlinson:

Anything else? Oh, this is so funny. You guys keep adding time to the clock.

Jim:

Well, that's because you're over.

Tom:
No, we're over. [crosstalk 01:10:26]

Anne Tumlinson:
I'm so sorry. You guys all want to go, okay. Thank you very much.

Steve:
We're about to get the hook.

Anne Tumlinson:
I was like, "How did we get all that time?"

Speaker 8:
[inaudible 01:10:32]