A Major Emerging Opportunity for Senior Living

Elaboration

One of the biggest growth and revenue enhancement opportunities for senior living is the intersection of clinical medical delivery with communal living and onsite long term care services. It's no secret that healthcare in America costs way more than in other comparable countries of the world. That handicaps America's economic competitiveness in a global society. Senior living is uniquely positioned to help address this challenge. The industry can benefit from taking advantage of this opportunity.

Community Medicine.

At one time, when the West was young, the leading citizens, often the wealthiest folks in town, would invite and underwrite a physician to come to serve the community. It worked a bit like today's concierge medicine. The local notables would each subscribe to pay a share of the physician's livelihood. In return, they would get priority medicine. Beyond that elite, though, anyone could consult the physician and payment was often in kind, eggs or produce or whatever the patient or the patient's family could afford.

Medicine then was relationship medicine. People knew their doctor. Their doctor knew them, too. In a community everybody knows each other. By today's standards, the medical care of a bygone era can seem primitive, but many yearn for that community acceptance in a more pastoral time.

Narrative Medicine.

Modern technical medicine has prolonged life and vitality by decades, but it has lost much of that human touch. Medical practitioners like to talk of "narrative medicine" with the message that every patient has a story and every physician ought to listen to those stories. That's an approach to bringing the human touch back into medicine. We prefer relationship medicine, but before we get into that, we'll take a look at the narrative medicine movement.

Beginning in the 1990s, narrative medicine became a popular part of medical education. Middlemarch, a novel about mid-19th century British medicine was a popular "medical" text for aspiring physicians. The idea was that physicians could gain insight by applying techniques of literary analysis to patient narratives.

That's not going to happen within the framework of a twenty-minute time slot. The only story that seems to matter with today's in-and-out reactive medicine is the story told by lab results or orifice probes while the patient is sedated.

Back To Relationship

We pay a price for that time-limited, computer-centered, dehumanizing of medicine. Mandated reimbursement protocols, an artifact of the rise of government requirements, obligate the physician to spend as much time typing into a computer as face-to-face with a patient. We now are left with reactive commercial medicine. Senior living communities have the potential to restore that old-fashioned familial style of medicine.

Bringing together clinical services with long term care capabilities is proving able to improve geriatric healthcare and to bring down costs at the same time. The demand for medical services (and the associated cost) accelerates exponentially with advancing age. Moving from a reactive medical model toward a relationship model can make a hugely positive difference.

When you think of the share of total nationwide healthcare costs that is dedicated to geriatric care, the potential for savings is manifest. The opportunity to improve geriatric care and to reduce the burden of that care on both patients and the system becomes more compelling the more one thinks about it.

Revenue Opportunity.

Senior living is positioned to be the driving force to bring about this economic model and to harvest the associated gains in the process. Think about it. Almost all clinical care today is delivered in a doctor's office, which may be at a distance from where the patient lives. Over

the course of time, a geriatric patient may acquire half a dozen or more specialists who schedule recurring routine follow ups.

Each of those "visits" requires transportation and time. Many are not necessary or beneficial. Senior living has a concentration of people subject to geriatric medical challenges. A primary care physician on the premises can provide a valuable service for residents. "Going to work" is gradually replaced by "going to the doctor." It's a waste.

Where's there's waste, there's opportunity. Big time opportunity, as Amazon has illustrated for retailing. Senior living is positioned to be the Amazon of geriatric medicine. What can make it better, is the opportunity for the geriatric physician to get to know residents as individuals. As the residents move through the common areas, they may encounter the physician.

Those casual social meetings provide opportunities for more meaningful interactions than is possible in the forced, time-compressed encounter in a physician's office. We've learned from PACE programs (Program of All Inclusive Care for the Elderly) that those peer physician relationships with residents result in better outcomes at lower cost. That's a huge opportunity.

Financial Analysis.

That brings us to the comparative economics. California Code, Health and Safety Code § 1375.9(a) specifies "A health care service plan shall ensure that there is at least one full-time equivalent primary care physician for every 2,000 enrollees of the plan. The number of enrollees per primary care physician may be increased by up to 1,000 additional enrollees for each full-time equivalent nonphysician medical practitioner supervised by that primary care physician."

To analyze the economics, we can use that 2,000 to 1 ratio as a starting point. For this purpose the best information that I have would assume that a typical CCRC has an average of, perhaps, 400 residents of whom we speculate that a third might opt into the convenience

of onsite routine medicine. In the absence of hard data, all we have are judgmental estimates based on experience.

That would mean that a physician spending a day at a CCRC once a month, and assuming 15 active working days per month, could have the same patient load as an office-bound physician. Of course, such a physician might spend half a day a month at a smaller CCRC and more time at a larger one. Many, perhaps all, large size Erickson communities already have clinical medicine onsite.

Quick Take: the economics can work. The PACE collaborative model shows that it can result in greater patient satisfaction and better outcomes. It can also make the care commitment of CCRC living more attractive and more credible. Moreover, the evidence is that PACE reduces medical costs substantially.

Partnering Options.

Of course, a CCRC could take the initiative and offer a proprietary Medicare Advantage program, contracting with hospitals, labs, and other facilities for needed services. That would, however, be outside the expertise of most CCRCs. Better is to contract with a local medical provider organization to provide the services in onsite space leased from the CCRC. The lease can be priced to share gains between the provider organization and the CCRC.

One wonders, too, why a large staff model health maintenance organization like Kaiser and its affiliated physician organization, Permanente Medical Group, doesn't already deliver a service like this. Most medical enterprises may simply be too mired in the visit-driven traditions of the past. Instead, most of clinical medicine as a senior living opportunity has come from the genius of Lynne Katzmann, Founder, President and CEO of Juniper Communities. Click here to read of her initiative, innovation, and imagination.

PACE programs, mentioned above, have also demonstrated the potential, though those programs have been constrained to Medicaid eligible participants, who would otherwise require skilled nursing care, and who apply and are approved by authorities. Those are tough political constraints, though the experience has been very positive.

My exposure is to the OnLok program in San Francisco and the St. Paul's program in San Diego, though there are others across the country. One publicly traded firm, InnovAge Holding Corp., has sought to create a profit center around PACE. InnovAge, though, has struggled a bit after the Centers for Medicare and Medicaid Services found deficiencies during audits of its programs in California and Colorado.

How To Learn More.

There is growing interest in this emerging opportunity to allow CCRCs to offer more fully integrated healthcare responses to the needs of aging residents. There is an invitation only conference scheduled in Arlington, Virginia for December 1st, but anyone can attend the more in-depth conferences on Medicare Advantage programs that RISE Health regularly offers.

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