4sight Health Roundup
Boomers or Bust?
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David Burda:
Welcome to the 4sight Health Roundup podcast, 4sight Health's podcast series for healthcare revolutionaries, outcomes matter customers count and value rules. Hello again, everyone. This is Dave Burda, news editor at 4sight Health. This is a special edition of the Roundup. We're gonna talk about how traditional providers can expand services for seniors with Julie Murchinson, partner at Transformation Capital and our special guest, Mark Shaver, senior Vice President of Strategy, physician Services and Business Development for Upper Chesapeake Health, which is part of the University of Maryland Medical System. Mark also is the former senior Vice President of Business Strategy and Health Systems initiatives for Welltower the healthcare Real Estate Company. Prior to Welltower, Mark spent 18 years at Johns Hopkins Medicine, culminating as Vice President of Business Development and Strategic Alliances. This strategic alliance business will come into play later in this podcast. Mark, welcome to the 4sight Health Roundup podcast.

Mark Shaver:
Great. Thank you for having me here today.

Burda:
The idea for this special episode came from a lot of different places, but at the top of the list is a new report released by the US Census Bureau. It said the number of US citizens age 65 and older rose, 12.3% last year to 61.2 million people from 54.5 million just four years earlier. In 2020, it will be 61.2 million people plus one this year as I turned 65 in April. The question is whether the current healthcare system is ready to handle the boom and boomers like me when our poor health habits over the past six decades or more start manifesting themselves in multiple chronic diseases. Yet at the same time, medical advances are keeping us alive longer. Look out. Here I come. Mark, let's start with this question. Are the market dynamics I've described more seniors, more chronic disease, longer lifespans a market threat or a market opportunity for traditional healthcare providers and why?

Shaver:
Yeah, David, thank you. So at, at University of Maryland we often start our discussions with connection to purpose. So mine, for me the care of seniors, complex seniors is something that I've, through my career, become deeply passionate about. And, you know, as I thought about your question more than a threat or opportunity, it's, it's I view it as sort of a responsibility that we have as providers to take care of the communities that we serve. We wake up every day to serve these communities. And for most health systems, Medicare beneficiaries have become more than half of the of the patients that we care for. And in our system, something that's unique at the University of Maryland Medical System is we actually provide over 25% of the hospital-based care in our state. So we think about the care of complex seniors often because as the largest provider of care in the state and with you know, the care of complex seniors increasingly being a challenge, you know, how we think about and how we provide services, we need to think differently, act differently, use technology differently to, to serve our community.

Burda:
Got it. So it's a responsibility, not necessarily a threat or market opportunity. That, that's great. Thanks, mark. Julie, any comments or reaction to what Mark said?

Julie Murchinson:
Well, first I'm not surprised by what Mark said because he is one of those unique executives in healthcare who has always you know, really had his heart in the right place around what needs to be done. But he's one of the most creative and innovative leaders when it comes to how do you actually do that? And, you know, it's been interesting to watch his career from Johns Hopkins to well tower, right? Very different company profile now to the health system that's providing at over 25% of the acute care like it, you know, it's a, a very different system. So, Mark, I know you've been involved in, you know, at Maryland, a lot of CMMI related work, especially, you know, the all payer system. Like, you know, I'd love to hear a little bit more about how you think about how UMS has taken that responsibility.

Shaver:
Yeah, I think a great example of something that's been unique in Maryland is in, in 2019, in, in partnership with CMMI center for Medicare Medicaid innovation, the Maryland Primary Care program was launched. And what it allowed us to do, as you guys might know, we, we have much lower Medicare Advantage penetration in Maryland, where about 25% versus more than half in, in the other parts of the country. And what it's allowed us to do is get resources, funding, operational metrics and data to allow for a more team-based care environment where the primary care providers are working hand in hand with behavioral health and community health workers completely integrated within our practices, and then been able to leverage the state's data analytics and, and sort of data information exchange to provide more, not just medical care and preventative care, but also social care and behavioral health services. And I think it's an example of where in Maryland we've been able to do unique things to help drive better health outcomes, but also be very mindful of the ultimate total cost of care. And some, some of that's gonna shift in over the next couple years as we move more towards this national ahead model. But it's been a really interesting example how in Maryland we've been able to harness a, a different model of delivery of primary care.

Burda:
Yeah, I think that stat you threw out about the lower penetration of MA plans is pretty revealing, right? That's that's almost like a biomarker for different healthcare markets, right?

Murchinson:
That's right.

Burda:
Mark, my second question is what care delivery models have you seen that convert those market dynamics that you've described into opportunities to improve care and lower costs? So give me an example or two and why they work.

Shaver:
Yeah, what I, what I think is, you know, and some of this goes back to my years at HO at Hopkins and working with some of our amazing geriatricians; I grew up really understanding some of the new ways in which care can be provided in the home. And so whether you call it hospital at home, acute care at home, there's been, you know, data over the last 20 years, some of it was research oriented around how we can achieve better outcomes for CHF or COPD patients who meet a social criteria where care can be introduced in the home, and what COVID allowed, it's sort of forced an ability for some of the care to be introduced in the home. And, and what's what's happened since then is, you know, we've seen the creation of companies like Medically Home and Contessa, which will soon be part of UnitedHealthcare. I'm a big fan of Allina spun out a group called Inbound Health. And what these groups are doing is providing the tech backbone, but also some of the home-based operational care for health systems to partner, to bring and introduce acute care models in the home to help keep patients outta the emergency room, to keep patients out of some of the inpatient units. And one of the things we're, we're tracking is how systems like Mass General, I think they're taking a very unique approach right now, today they have between 80 and a hundred patients in a daily census that are cared for the home through some of the partnerships they have. And their ultimate goal is to get to a daily census of about 300 patients, which essentially is a large community hospital, right? So in the state of Massachusetts, Mass General is looking to essentially create inpatient capacity in the home equivalent to a large community hospital. And that's to meet some of, you know, David, your point earlier about the growing healthcare burden needs, but also move to some of the market dynamics where patients and families want to see more delivered in a traditional home and, and bring more complex services into the home. So I think it's really unique. Obviously, there's some policy implications for how these are gonna be paid for in the long term, but I'm quite hopeful that we could see the adoption of more of these home-based models.

Burda:
Got it. Yeah. Behold the power of the pandemic, right. To change the market. Yeah. fascinating. Fascinating. Thanks, Mark. Julie, any comments or reaction to what Mark described?

Murchinson:
Well, I mean, Mark, you've always been the one who focuses on business models at work and how they pencil out in some sort of sustainable way, right? So, I'm not surprised to see you pointing to these. It is kind of amazing to think about the capacity that MGB is looking at. And, you know, I like, I'm amazed when you think about the fact that you all in Maryland haven't had all the competition or even a lot of the private ideas, even like the medically home you know chasing after your market and embedding in your market. So it seems like you all have a great opportunity to almost leapfrog what a lot of other systems have struggled with, with some of those in their market as well.

Shaver:
Yeah, absolutely. I think, you know, one of the challenges of our historic model has been, it's very hospital based, and we've thought about everything from the core of the hospital environment, whereas in other markets, because of the acceleration of Medicare Advantage and

other things, the payers have helped drive some of the acceleration to the home. Some of the partnerships, acquisition of practices, we don't have that as much in our market. And it'll be interesting as we evolve to see how that's introduced.

Burda:
Yeah, you could run forward without constantly looking over your shoulder. Right. and you get a lot farther <laugh>. Thanks, M ark. All right. Last question. Tell me about partnerships. Why are partnerships or strategic alliances, if you will, the path forward in expanding services for seniors specifically or for other areas of care generally? You know, what is it about partnerships that make them an attractive vehicle for incumbent healthcare organizations?

Shaver:
Yeah, as I was thinking about this, I think there's two things I want to talk about. One is how some health systems have partnered with payers and Medicare Advantage plans. And the second is a little bit about technology and some of the emerging AI. So on the first topic, you know, I've been tracking pretty closely how groups like Scan Health Plan recently partnered with Sutter to help bolt on the ability to run the managed care and NMA component of it, and integrate that with Sutter's clinical delivery system. So I think there's a lot that'll will come of those types of partnerships. An example I wanted to share, when I was at Welltower… so for those who don't know, you know, Welltower is the largest owner of senior based home home services, assisted living, memory care independent living. And we had a very unique business portfolio, which was c we called it housing that's affordable, not affordable housing. So we had in markets like Scranton and Cincinnati and others, these housing units, and we described it as $50 a month matter to these seniors. So it was a, you know, working class retire population in some of these second and third cities. And in, in Pennsylvania, we were able to do a unique partnership with Geisinger, where Geisinger had developed their 65 forward primary care program, so senior targeted primary care with their Medicare Advantage product. And what we were able to do was integrate and introduce Geisinger into our residential communities where $50 a month mattered to our seniors, introduce the MA product, which helped reduce the out-of-pocket expense for our seniors, and then have Geisinger bring social programs, medical programs community-based health engagement to a population who couldn't afford private pay assisted living or private pay independent living. And it was a very unique model. And what was interesting from the payer side, we, we weren't as concerned from kind of the real estate side, but they were able to secure 30% adoption of those Medicare Advantage products, which was really unique, you know, to be able to, to penetrate that. So that was an example of bringing traditional healthcare with payer based tools into a residential senior model for somewhat of a forgotten middle class that we have in our senior population.

Burda:
I recall it wasn't, didn't Anitta do something like that? I seem to recall they, they, they built these villages like that too, or am I…?

Shaver:

Yeah, I mean, I think there's a bunch of models that have existed and trying to figure out how can you do these types of models at scale and in submarkets with either systems or payers, I think is, that's really one of the challenges. And you know, David, in, in your introduction, you were talking about the number of Medicare beneficiaries and the growth of the 65 plus population, but one thing we forget is that the first boomer in 26 is gonna turn 80. Right? <laugh>. That's gonna be striking in terms of the advanced complex disease, the advanced dementia and other challenges, acceleration of things like Parkinson's, which pose a, a large societal challenge in addition to the medical challenge too. Mm-Hmm <affirmative>. So that's an important element too.

Burda:
Thanks Mark. Julie, any reaction or comments to what Mark said?

Murchinson:
Well, on this front in particular the fact that you've had experience Mark thinking about this forgotten middle that you've talked about there're the Welltowers and the ages and those who serve those who can afford it, and then the, our safety net system. But to be able to work on sustainable models through partnerships that expand health system footprint, I mean, that's, you know, it's material, it hits a large percentage of the country. So keep on trucking with that.

Shaver:
Yeah, really exciting.

Burda:
Thanks, Julie. Now I've been asking the questions here. I'm gonna turn it quickly over to Julie to see if you have any other questions for Mark.

Murchinson:
Well, Mark, I guess two different types of questions. Let's first talk about my favorite topic technology, <laugh>. So when you answered the partnerships question, you really wanted true partnerships, which I think is really the crux of the question. But talk a little bit about where university of Maryland has been able to adopt technologies that have made a difference, efficiencies, revenue might be a different situation, et cetera, or where actually your reimbursement model has held you back perhaps in adopting.

Shaver:
Yeah, I think the reimbursement model has been great for us in that it does have us think of Medicare, Medicaid commercial as, as the community which we serve. So we, we haven't had to historically delineate between those populations, which I think is good. I think what it has challenges do we have the investment capital and the balance sheets to be able to invest in technology. And I think that's probably Julie, the bigger challenge. Some of the things, and I'm very fortunate, there's a small group of us that sit on the systems AI council and I happen to be one of those. And what I really like and, and what we're spending a lot of time, especially with the clinicians, is helping them understand we need to learn to work with the tools that are coming

out. So we've introduced DAX Nuance, which is one of the ambient listening tools into our outpatient practices. And, you know, the tools aren't perfect now, but what they are doing is allowing for a much more efficient clinical workflow in interacting with our patients. And the tools are only gonna get better. So,we've really said, Hey, let's use the technology we have today, the tools are gonna get better, but learn how to work within those technologies. And so I think tools like Abridge and DAX Nuance will absolutely help be a multiplier in the outpatient in particular environment, which we need. We need to increase access for all of the reasons we've talked about this morning. The second thing too is I'm quite hopeful that some of these new AI tools will also be applied in the nursing environment. I think our frontline nurses are clamoring for better tools to allow them to spend more time with the patients and less time documenting. And so some of the new tools I think will be helpful. At the same time, you know, one, one thing that's missed is a lot of the inefficiency in our system also comes from readmissions. And when you look at what drives readmissions in our country about a third of the patients are coming back within seven days. And the about a third of those individuals are really coming back because of medication issues, not having the right meds, the meds are interacting because we're not taking patients off of the meds, or because of affordability, patients aren't able to afford their meds. And so using some of these AI tools to help synthesize anybody who's had a parent discharge from a hospital or discharge to home health knows how difficult it is to just simply understand the instructions of what mom or dad or aunt or uncle should be taking. And so some of these AI tools are really helping to synthesize the information for our clinicians who could then help synthesize it and better educate our patients. So these are opportunities that have massive impact both to the capacity we have in our system, but also the affordability in our system. So I'm really hopeful that whether you call these vendor partnerships or tech solutions or what the acceleration of the integration of these tools into delivery of cares is gonna be massively important.

Burda:
Yeah. Don't, don't wait till they're perfect. Right. Is is the message there, and Julie, you said you had another question for Mark.

Murchinson:
Yeah. Well, Mark, this is a softball, but I've known you for a very long time, and I've seen you in different phases of your career. And you know like I said before, you think in models that work and models that work sustainably, but I know that you also get a lot of opportunity to do things as part of the University of Maryland system. How, how was, you know, this last phase at University of Maryland impacted you personally? What do you get to do that you love or like share something that's been, you know, meaningful to you?

Shaver:
Yeah, I would say, you know, two things. One, is very recent. So last Friday as part of the primary care program I mentioned earlier our community health workers go and deliver food to patients and families who are food insecure. So I had the really unique honor to go and work with our community health workers and go visit a couple of our patients last week. And, it's very humbling to be invited into somebody's home and also humbling to bring them nourishment. So

we are in a somewhat rural geography here, north of the city, and so bringing fresh produce and food and spending some time with our patients who are our community. But when you start talking to them, there's a sense of loneliness. There's also a sense of gratitude. One of, Terry, who was one of the patients I visited with her, she's a three time cancer survivor, really relied on our health system over the years and really was grateful for the community, you know, for the system coming into her home. So that's just really humbling and you learn a lot. You know, we think of business models and complexity and scale, but it's really in service of the community. And I think some of our seniors really, really do need our help. And, another example I would just give that maybe was my most significant learning in my career was, you know, as we were coming through Delta and Omicron variants of COVID, it was really difficult. And we had to volunteer to help. And you know, pretty much every other weekend I volunteered in our emergency department. And it's not a place that I typically am comfortable, but you really learn about the challenges and the suffering in the community, and you also learn how hard our frontline workers, our nurses, the docs, the specialists, work to try and keep our community healthy. And so that then informs, you know, how we should be accelerating some of these investments in technology that informs some of the challenges that I think when we go to some of our conferences, either our policy colleagues or our tech colleagues, they sort of pontificate about serving. But unless you're actually there, I'm not a clinician. I can't do what our docs and nurses do, but I can help them. So helping the people who help our community, I think it's just a very humbling experience.

Burda:
Yeah. Firsthand experiences, firsthand knowledge. Right. better results.

Murchinson:
Yeah. And Burda, Mark is the one who, you know, whenever I call him and ask him about a certain, you know, problem I'm hearing, or a company that we're interested in, he's the one who always pushes on something that like, I haven't thought about. So whether it's like pushing on the nurse adoption for ambient listening and how that's different or pushing on kind of like what people are really experiencing in this part of the delivery system you know, it's, you're unique in that way, Mark. So thank you. I appreciate it.

Shaver:
Yeah. I also thank you, Julie, I was talking to a friend of ours, Walter Jen, who's been a tech entrepreneur for, for many years; and he was pushing the opposite too. He is like, yeah, that's all important, but make no mistake, hundreds of millions and billions of dollars are being invested by the major tech players in the acceleration and the creation of these tools. And you need to be paying attention to how these tools can be used in healthcare, because healthcare has been too slow to adopt. And I think that's also an important balance too, Julie. Yeah. You know, for everything we've learned by serving the community, we also have to be mindful that we need to do a better job. And we need to leverage the balance sheets and the investments of some of these other groups out there to, to bring those capabilities into the nonprofit health systems and into policy and public health, et cetera

Murchinson:
Well, your friends, like Walter and I are trying to do that. So <laugh>, we're on the same team.

Burda:
No, I'm starting to feel better about my chances for the next 20 years. So the question is, do I order one more pizza on a Friday night? 'cause My future is bright. Thanks to you guys, <laugh>, we'll see. Great discussion, Mark, thanks again for being our special guest today on the roundup.

Shaver:
No, my pleasure. Thank you both for having me, and you know, we have a lot of work and a lot of responsibility in, in caring for our community, so thanks, thanks for the opportunity today,

Burda:
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