BDO

Health and Life Sciences Rx PODCAST

# EPISODE 6:
# PREPARING FOR THE FUTURE OF ELDER CARE

INSIGHTS FROM THE BDO CENTER FOR HEALTHCARE EXCELLENCE & INNOVATION

## INTRODUCTIONS

**Steven: This morning, we're honored to begin today with a fireside chat on the future of elder care with Tom DeRosa. Tom is the CEO of Welltower and is an innovative and passionate healthcare and business leader. Welltower is a REIT with a strong focus on seniors housing and the future of elder care. And as you'll hear from Tom, they are so much more than their technical REIT categorization. My colleague Patrick Pilch is here to guide the conversation right after this introductory video.**

**Patrick: Good morning, everybody. Morning, Tom.**

**Tom:** Morning.

**Patrick: Thanks very much for joining us. I know Steven [described] Welltower as a REIT, but I view you as a healthcare company, so that's the difference.**

**Tom:** Thank you, Patrick.

**Patrick: REIT's a tax structure, more than anything else.**

**Tom:** Thank you.

## THE FUTURE OF SENIOR CARE [1:07]

**Patrick: So last month, you had a very successful investor day. And one of the topics was obviously the future of senior care, where you have a deep focus, obviously. Can you tell us about Welltower's vision for where senior care is going and the role that Welltower is playing in that revolution, if you will?**

**Tom:** So, I think most of us know that modern medicine has given us an extra 20 years of life. So, if you thought you were living to 85, very likely you're living to 105. And some of that is due to the fact that we introduced a class of drugs called statins. Some of it has to do with the fact that many cancers, which were death sentences for our grandparents,

## TOPICS DISCUSSED INCLUDE:

are now chronic disease states. Some of this has to do with the fact that we've stopped smoking. Thirty years ago, you'd all be smoking. I'd be smoking while I was giving this talk. …

So, based on the knowledge that if you change behavior, you might get a better state of well-being, plus some of the advances in healthcare and medicine, we've been given this extra 20 years of life. But the fact is, most of us have not processed that, and we don't live in a world that has processed that extra 20 years of life. And those of you in this room who've dealt firsthand with parents or grandparents that have lived into their 90s, and in some cases 100s, know the challenges of these extra years of living. And key to the challenges are two diseases that have taken the place of heart disease and cancer in creating challenges for seniors. Some people will say this isn't a disease, but I call it a disease. It's called frailty. The body starts to break down as we age. Our bodies, unless you are prepared to live to these ages, are not prepared to be a vessel for you to live productively in into your 100s. And then there's a disease which we call dementia, which for most people starts at the age of 85. And for many of us, it will remain relatively nascent into these additional 20 years. But for many people, it starts to escalate. So, this situation is going to cause tremendous problems for the healthcare delivery system. We're just seeing the beginnings of it today.

And where Welltower fits in all this is that we believe we have to think differently about where and how this population lives as they age. Because as we age, we start to lose many of the elements that keep us healthy and well. And those are the social determinants of health, which is a term that we use a lot lately. So, we're engaged principally in a business that provides settings of wellness for this population, that keeps them safe from a physical standpoint and from a drug standpoint. For lots of people, as they age, it's really hard to take their drugs. Many people take 10 to 12 to 15 drugs per day. And if you don't hear well, see well, smell well, you may not take those drugs appropriately. That could land you in the emergency room. We can't afford that. We keep people hydrated. We try and keep their bodies moving. We keep them well nourished. Some people would say this is not healthcare. But I argue that this is fundamental to healthcare. But unfortunately, this concept hasn't been broadly embraced, yet.

## SOCIAL DETERMINANTS OF HEALTH [5:48]

**Patrick: Right. So, let's follow up on the social determinants of health. We have a common friend, Karen DeSalvo, who was here last year. And she now sits on your board, which is tremendous. One of the aspects of care that Karen last year talked about was certainly digital health, but also social determinants of health. How are you looking at that? We just mentioned it briefly, but how are you looking at that in terms of your business going forward, and what does it mean? Because I agree with you. We do see a lot in terms of—healthcare is not just a hospital, not just a building. It's something beyond that.**

**Tom:** So, we know because of this residential senior care business, which really does maintain social determinants of health for this population. By the way, a population that has money because this is a private pay business. Medicare pays for none of it. And this is all out of pocket expense. But I will tell you, people who live in a wellness umbrella as they age go to the ER far fewer times than someone who is living independently. And when they do get admitted to acute care, they stay far fewer days because they arrive in the most optimal state of wellness that they can have for their age. We actually believe that this shouldn't start at 85. I mean, the average move-in age is in the mid-80s today into senior care. And that was not how the business was conceived. The business was conceived 30 years ago in the U.S., and people moving into residential senior care were in their 70s. Now, average life expectancy was 78 in the early '90s. So, people lived in these buildings generally for three years, their later years. And sometimes when they passed—they died of heart disease, they died of some other acute issue. They often died either in the community, or they would move home with a family member and die in hospice care.

What's happened to residential senior care is it's become private-pay nursing. People are moving in when they're really sick, when they are very frail and when they have lost their cognitive skills. And families realize they've exhausted any opportunity to care for these family members productively in their homes. So, they move into residential senior care. It's very expensive, and so people wait to the last minute to do it. In Welltower, the average monthly cost is $9,000 a month, and that's out of pocket. You have to have a lot of money to spend $9,000 a month out of pocket. And the costs go up from there. So, we're thinking about the future and saying we don't want to be—anyone who runs a company, you don't want to be in a reactive model. You want to be in a proactive model. I think proactive is thinking, "How do we take a lot of what we've learned about putting an at-risk population in a setting of wellness, and how do we move that into a younger age?" Because the fact is, I just turned 61 on Saturday, and I don't go, "I'm healthy." I'm kind of what I call a 'fish-egan.' I'm basically a vegan who eats a little fish. So, I'm a pretty healthy eater. I try to exercise. And I don't really use the healthcare system. But New York Presbyterian, who's my local, shouldn't meet me for the first time in the emergency room. They should know me now, but they don't know me. They don't. They have no reason to know me.

We think that a lot of the population needs to get on this wellness wagon earlier, like in your 60s. Because a lot of people don't have the infrastructure that I'm fortunate to have in my life. Many people don't have that. Most people don't have that. So, creating places where people can live this wellness-oriented life and maintain social determinants of health allows someone, when they reach that age of 85, not to show up on our doorstep because

they've exhausted every other possibility for care, but actually, to push that out a number of years. So maybe they're showing up to live with us at 101 in that classic residential senior care model. But maybe there's a model that they've moved into at 72 that's allowing them to improve their wellness and health footprint and—here's a big point—narrow their economic footprint. Because I don't think most people have the capital to live the extra 20 years. Who's going to pay for that extra 20 years? If you stop working at 65 and you live to 105, it means you've not worked possibly for half of your adult lives. And I can tell you I don't have a pension. My company doesn't offer a pension plan. So, I think there's a lot to consider, and I think rethinking how people live, and how people interact in what I think will be a newly defined healthcare system, is something that we're very focused on.

## THE HOUSING AND REAL ESTATE COMPONENT [11:21]

**Patrick: So, I think we—just quickly because we're both Columbia Business School grads—we have the chair of the program here, Bunny Ellerin, who arranged all this for us. We're big on numbers, and you say $9,000. One day in a hospital is not $9,000. And so, I look at it from the standpoint of a risk model. You're actually keeping people healthy and out of a high-cost center that would be picked up by Medicare at that point.**

**Tom:** Exactly.

**Patrick: And so, there's got to be a bridge to that, given the volume of population that's aging, at the pace at which it's aging of 10,000 people a day in this country turning 65. So, in that social determinants of health, but also there's a housing component too. And we had a conversation about that just a couple weeks ago. Can you talk about the housing component in terms of what's happening in the country?**

**Tom:** Yeah. I'll tell you that—let us go north of the border first to Canada. So, in Canada, they have a very, obviously, a very different model because the payer and the provider are the government in Canada. Canada does not have a private-pay assisted living business like we have in the U.S. What they do have is what's called independent living and we're—that's a business that Welltower is engaged in, in Canada. And in the province of Quebec, 20 percent of people 75 and up live in congregate housing. These are essentially, low-cost apartment buildings. People pay out of pocket. Why does 20 percent of the population of 75+ elect to live in a congregant setting in Quebec? Well, the government, who is again the payer and the provider, figured out: Isn't it better as people age to have them live together? If we have to provide healthcare to 400 people living in 400 different homes, wouldn't it be better if they all lived in one building or two buildings? So, they've actually given people in Quebec a small tax incentive. We're not talking about a big tax incentive. We're talking about a few—this is a product that cost the consumer anywhere between $1,500 to $2,500 dollars a month to live. And they get a couple of 100 in a tax break. But it's helped them change behaviors and get better outcomes. And I think we need to be thinking about this. And where I think we can change behaviors in the U.S. is when you get the providers and the payers together with us to start to create some level of incentive that will get people out of their homes, their historic homes. And that's a hope we can talk a little bit about. I have a whole theory on that. You get them out of their historic homes which are working against their health and wellness and get them into places that the payers can try, and influence behaviors and the providers can efficiently deliver healthcare outside of a hospital.

**Patrick: That makes sense. I mean, a lot of sense. We've been talking so far about care. Now there's [also] a real estate component, and we've had conversations about this. So why should—and I'm putting out a question for you, but why should the healthcare community investors pay more attention in exploring partnerships with organizations such as yours, such as Welltower's?**

**Tom:** Because one of the things that you'll hear throughout the J.P. Morgan Healthcare Conference and lots of people are engaged in this concept, healthcare at home. That's a great concept. But what does the home look like of the average Medicare senior or Medicaid senior? Can you really, reliably provide healthcare in that home? We are home. What we're calling for is how do we redefine what home means for an aging population? Because if you can bring people into environments that maintain social determinants of health, yes, you can deliver healthcare in this home. I'm a big believer that there's a big percentage of residential real estate in this country that is obsolete. And we have not come to terms with that yet. Remember that so much of residential real estate in this country was built for returning veterans of World War II and the Korean War where there was tremendous new family formation and there was a lack of housing. Even my parents who got married in 1945 moved in with my grandparents because for a short period of time because there was no place to live. You couldn't find an apartment in New York. So, I'll use this. There was the Levittown phenomenon. So, we built Levitt towns of three-bedroom, one-bath houses in the suburbs. So, there was a massive migration out of the urban centers to this housing stock. And what happened over time, through the '50s, '60s, and '70s, these old urban neighborhoods of the major American cities started to become marginalized because people didn't want to live in the crumbling old buildings. They wanted to live in the nice three-bedroom, one-bath house with a small backyard where their children could ride their bikes to school. That was the American dream. That's what made America great.

So, let's fast forward to today. You have lots of seniors still living in these homes. And many of them are lonely because they live as shut-ins because they can barely afford to pay the utilities,

the taxes. They can't remove the snow in the winter. They wind up sitting in the house. And unless they have a family member who can come and look in on them, their health significantly deteriorates. Here's the other issue. What's happening in these communities around the country? The next generation—I will tell you, my kids who are in their late 20s don't want to live in those communities. They want to live in the old crumbling neighborhoods, the once crumbling neighborhoods of the urban core. I always said if you could wake my father up out of the ground and say, "Hey, do you know your granddaughter lives in Williamsburg?" He would say, "What happened to her? She was such a nice little girl. Is she a drug addict? How is she living in Williamsburg? I did everything I could to get my family out of Brooklyn." So, we've had this massive societal move. People are living in the urban centers. And what's happening is, what were once ghettos are now vibrant urban neighborhoods. And what's happening is the Levitttowns are becoming ghettoized and lonely places and this will significantly work against our ability to deliver healthcare with good outcomes at a reasonable price. So, these are lofty concepts, but we're trying to do our part. And I think if you bring together, if you can create incentives—because I don't expect the U.S. government is going to give us those incentives in the near term.

My mother was in residential senior care until she passed this summer that cost $28,000 a month. And she was paying that out-of-pocket because she required—she was in a dementia care residence at $15,000 a month and she required a private duty nurse 24/7 at $13,000 a month. Interesting though, before she moved into residential senior care, she called 911 and went to the emergency room at North Shore Hospital at least once a week. At least once a week. When she moved into the residential senior care she never again, for six months, went to the ER. And when she died, she passed very peacefully in her bedroom. Just didn't wake up one morning. We should all be so lucky. She got no benefit. The government got all the benefit. She received no benefit, essentially, once she took herself out of the system. We can't afford to have my mother, in scale, accessing the emergency room one and two times a week because they live in the wrong setting. And so, I do think we can—we're working hard to look at how do we create incentives to get behaviors to change?

## BIGGEST ISSUES FOR AGING POPULATIONS [20:54]

**Patrick: So, would that be along the lines of—well, a couple of things. What are the biggest issues with respect to aging populations that you see? Is it housing? Is it access? Is it the payment model that we have currently in place? Is it the lack of coordination? I mean, it could be all of the above.**

**Tom:** I think it's a lack of coordination. I think you said it, Patrick. I think we have to do a better job of coordinating this wellness and health journey for people. Some people are lucky, and they have an infrastructure that helps them navigate this healthcare journey. But just understand, the majority of people do not. And if you don't have someone to help you or an entity help you navigate, you just become a massive liability for the healthcare system. And it is imperative that we do something to stop this. And we're not there today. But I will tell you that I've been talking about this for five years and I will say that five, four years ago it fell on deaf ears. If I just use the J.P. Morgan Healthcare Conference as a barometer. My team and I have been spending a lot of time with health systems and with payers who want to talk about this. So, if I sound a little bit like I'm putting a black cloud over the room. I'm actually encouraged by the dialogue that's starting to happen. And there are initiatives that are happening that are going to be great examples of what we can do to scale a better-coordinated model in the future. I mean, Welltower is engaged with payers and providers right now in piloting programs that I'm not going to announce or give you much detail about it because they're somewhat confidential. But you'll be hearing more from us in the future about some new models that I think will be quite compelling at addressing the issues that I'm talking about this morning.

## EMPOWERING SOLUTIONS FOR CONSUMER-DRIVEN HEALTHCARE [23:24]

**Patrick: That'll be great. Because I look at it from the standpoint of there's a lot of push on consumer-driven healthcare, right? And so, what are the empowering solutions? Well, part of it is if the infrastructure is not in place, you can have all you have if you want but if there's no connectivity to it, no coordination. So, you can be, obviously, the care deliverer but also the coordinator, integrate and bring everything together. And I think that that's where to your point, there's tremendous need.**

**Tom:** I also think that what I'm encouraged about is a renewed focus on primary care that we're seeing in this country. And I actually think that—we're big believers and we're doing this as a company, that healthcare and healthcare delivery and primary care can actually create community. Community in this country for the last 50 years has been created through retail for the most part. If retail's on your phone right now, how does that create community? But we're seeing healthcare delivery, primary care, wellness concepts, move into high street retail. Patrick said he's going to UCLA tomorrow. We own four medical buildings in a little town called Beverly Hills. And recently, UCLA has opened primary care just a block from Rodeo Drive. So, you've got Gucci two blocks away. And then you've got on the street, in what used to be a retail site, is now UCLA. I think that we need to make health and wellness accessible. And I think there are lots of different ways. Technology is enabling that. There are a lot of efforts to try and make health and wellness much more accessible. And I think

you're seeing healthcare delivery and health systems move out of the walled hospital campus more into the community. And again, maybe that's a way of not meeting me for the first time in the ER.

## PRIMARY CARE COMMUNITIES [25:48]

**Patrick: Right. That makes sense. I mean, again, retail has gone to your phone to a great extent but also healthcare has gone a little to your phone too in terms of connectivity. So how do you see that with respect to seniors—but also you talked about primary care. Primary care is everybody, frankly, right? How do you see that in terms of greater independence and greater management of that?**

**Tom:** Look, I just think there—I am energized by what I'm seeing happening in primary care. I think there are new primary care models being delivered and primary care is being brought into the community in a deeper way. I've spoken to a few people about a building in Baltimore in a neighborhood called Remington which was a marginal neighborhood of Baltimore. And there is a very nice affordable—not Section 8—affordable apartment building that was constructed in Remington. On the second floor of this building is 35,000 square feet of Johns Hopkins primary care. On the first floor is Walgreens and some other retailer. This has become an anchor in an emerging community in an urban center. And what it's doing is raising up the health and wellness profile of a community. And again, this is also tech-enabled. There are all these—it's just a great example. Unfortunately, there are too few of these but it's happening. And you look at these models. And we're engaged in a number of these models. This is a way to start to drive the responsibility for health and wellness to the individual at a younger age. It's a cultural change and it's very difficult to change culture. But when you start to put health and wellness as part of people's daily existence like Starbucks. If you put health and wellness in the same locations, Starbucks didn't exist really, 25 years ago. If you wanted to get a cup of coffee, you got one of those blue cups in New York with the Greek guys.

**Patrick: With the Greek guys.**

**Tom:** Fighting each other, right? From a guy on the corner. Best coffee.

**Patrick: Best coffee.**

**Tom:** We didn't know that we would actually have a place to go and buy coffee and convene with people. So, I think healthcare has to think a little bit like Starbucks.

**Patrick: That's a great point. That's a great point because that's a community.**

**Tom:** Yeah. Starbucks is a community.

## THE FUTURE OF ACUTE CARE [28:16]

**Patrick: Yeah, very much so. So, the merger between—we talked about healthcare, healthcare provision, housings changing, certainly with the growing population of seniors. But that growth is also going to have an effect on the current acute care environment, certainly, as chronic diseases are a big portion of our costs in this country. So how do you see it affecting the acute care industry and what has to change there in terms of acute care delivery?**

**Tom:** Well, again, it's hard to paint acute care with a broad brush. But I was with a very large health system CEO the other day who told me that in certain markets his acute care real estate is operating at 60 percent of capacity and it's just going down. I think in many parts of the country we are far oversupplied in acute care. And I think you have health systems that have recognized that they cannot continue to try and fill those acute care beds. That is a losing proposition: investing in those acute care beds if they're in the wrong market. And then you have health systems that have capacity issues. They don't have enough acute care beds. But those who are in markets that have changed from when this acute—a lot of acute care was built when frankly, the reimbursement system gave you an incentive to build acute care beds. But those incentives don't exist today. But that real estate exists today, and I think too many health systems have too much capital tied up in acute care brick and mortar that they will never get a return on. That is going to be a losing proposition. So, some of these systems that we're engaged with are thinking about what I've been talking about this morning and how do you replace some of that aging acute care with residential, with wellness housing? Where they could provide some services. And maybe, if the health system's a payer, they can create some incentives to get people out of the three-bedroom, one-bath house with the cracked driveway into this housing. Or will combine with another payer in the market.

I think that many health systems are under-invested in ambulatory care and over-invested in acute care. And I think that there are many who we're seeing, and I will tell you this, I've seen a dramatic change in mindset in the last two years. People that would not have talked to us two years ago or looked at me like I was crazy, now, are calling me and saying can we talk about this issue? So, I think we're going to see a massive change in a lot of the brick and mortar that was built over the last—pick a number—75 years to deliver healthcare. I think a lot of that is going to come out of service. And I think the capital that the health systems can harvest from that real estate should be invested in a next-generation class of ambulatory care and other sites of care that can give us a shot at lowering healthcare delivery costs and delivering better outcomes.

## MEDICAL INNOVATION AND THE CONTINUUM OF CARE [31:47]

**Patrick: You're bringing up an interesting point, because in the '50s when these hospitals were being built. A lot of hospitals, certainly, on the East Coast I would say, were being built, every town—you have your hospital, you have a school, you have your church, it's a community. So now it's changing completely with medical innovation, aging population. Again, it was a much younger country in the 1950s post-World War II than we have right now. So, this is going to change the continuum of care. So, in your role as CEO of Welltower, where do you see that in terms of where that whole continuum is changing? We talked about it. Let's sort of connect it all together. Where's skilled in there?**

**Tom:** Yeah, look, I think that skilled is an important piece of healthcare delivery. It became a four-letter word in healthcare delivery. But what I will always say to people, don't confuse an over-levered, private-busted, private-equity backed business like Genesis and an HCR ManorCare. Don't confuse that with the viability of the side of healthcare delivery. So Welltower took a lot of shots and arrows for staying in the post-acute care business but we've been there to reinvent this business. So, some of you know that we bought HCR ManorCare out of bankruptcy with a health system earlier this year. The ProMedica health system and Welltower bought HCR ManorCare. We have restructured Genesis. These are today, very viable sites of healthcare delivery. And if you speak to any health system CEO, they would say I need a viable, post-acute care partner in order to deliver my mission, but they need to be coordinated. What happened in the skilled nursing industry is that if Medicare is going to pay you 30 days, you keep somebody for 30 days whether they need it or not. I mean, that's ridiculous. If there's a coordinated model of care, you're working the payer, the provider, the post-acute care provider are working together, we can actually achieve better outcomes, drive better quality census into skilled nursing versus thinking I just have to hold somebody as long as I can hold them in the bed if that's what the government's paying me to do. So, I just think that there needs to be much better coordination, but it's very hard to coordinate.

## THE FUTURE WELLNESS SYSTEM [34:25]

**Patrick: So, I have a question with that because one of the questions I was going to ask you is what's the future of the senior healthcare system look like? But it's really not senior when you think about what your strategy is. You're really going into what's the future wellness system look like?**

**Tom:** Yes. Exactly.

**Patrick: So, can you lay that out, in your vision—so you're the king of healthcare. What would your vision be and what does that look like? And I'm not going to paint is it this? Is a that? Just sort of lay that out because these are all—this conference, obviously, isn't just a conference but this helps tell that story and shape it.**

**Tom:** Well, I think the first thing is how do you coordinate a population? So how do you coordinate population around the concepts of health and wellness? I think technology is just starting to play a role in this. But technology will have an enormous role in the coordination of a population, again, young to old. We certainly don't want to isolate the old population. That's why I think we need to build community around health and wellness. So, in the perfect world of healthcare delivery, you have a connected community of people, of sites, of care delivery, whether that be basic primary care to very complex acute care, enabled by technology that can as effortlessly as possible and as efficiently and cost-effective as possible coordinate people on a health and wellness journey. That to me is the future and within that it's really health and wellness is life. And I think we have to move away from healthcare happens over there and my life is over here. That's the problem. That's the problem. We've got to bring it all together and I think these efforts particularly, of the major health systems, to try and have more of a consumer-face, play a broader role in people's lives. I think it is very positive. I think the efforts that I believe you'll see out of the payers, to go from being thought of by their customer like the IRS. Like, okay, I pay every month to my health plan and I really hope when I'm sick they'll actually reimburse me for something. I mean, it's like the freaking IRS. I mean, that's not a good consumer model. That's not going to change behavior. That's a model of fear. I think there are efforts by the payers, and I think we're piloting some programs that's actually going to put a face on the payer to the consumer. In order to affect someone's heart and mind and body, you have to have a face. You can't be some amorphous institution somewhere out there. So, I'm optimistic. I'm actually, I said that I hope I wasn't too much putting a black cloud over the room, but I'm actually very optimistic. I think things are happening. I think they're going to happen very quickly.

**Patrick: I also think that what you're doing is certainly thinking about, as Medicare Advantage is growing so rapidly in this country, it affects their ratings too, with patient satisfaction too. So, it all connects together, so the payment incentives have to be in place certainly in order to move forward. And I think you touched on something very interesting that we see a lot of is this isolation. You cannot isolate seniors. You can't isolate populations. The community is very important, and Starbucks happens to sell coffee, but it is a community. It's not a coffee, coffee's there. So, it's just other things there. It's the reason why people come together.**

## BRINGING POPULATIONS AND LIVING ARRANGEMENTS TOGETHER [38:37]

**Patrick: We have some time for some questions from the audience and hopefully if people have any questions, I'll just take them and ask Tom and we'll go from there. Any questions?**

**Paul (audience member):** We were having a similar conversation at the table with some of your colleagues from the U.K. about how certainly, there's efficiency in bringing populations together and in living arrangements. But how do you make that happen? Have you thought about any realistic ways of making it happen? Because I think psychologically, I don't want to sound like libertarian or something, but in this country, people think strongly about their homes and where they live and the reason why they still, some of them anyway, why they still live in the Levittown in the house, is because that's the house they've loved and have always lived in. But I'm just curious about if there's been really some further thinking about how you generate that? I mean, one thing is to make very attractive senior living communities that people want to live in. Thoughts, further thoughts about how to do that?

**Tom:** Well, ultimately, the way that you could really change behaviors is by giving people a tax incentive for even if you got a small tax break for every dollar you spend to live in a setting that keeps you out of the system. That's going to change behaviors. I'm a big believer in something called 'nudge theory.' I think there are ways that a payer could create some small positive benefit that someone gets if they choose to live in a setting by which the payer can actually monitor their daily living. I mean, just think about the fact if you've got 300 seniors living in a community and on Oct. 1, the payer or the provider could go to each one of those people and give them a flu shot. You now have October, November, December to build up the immunity. That we know is going to have a great positive impact on the system. Because for a lot of those people, if you're giving flu shots in December, it's too late. So, we just think there are ways. The benefits are there. We can demonstrate that you get better outcomes through these congregant models. So, I just think there is without giving anything away, I think there's a lot of thinking going on, on the side of the payer around how do we nudge people? What type of benefit could they get if they lived in this type of setting? A lot of it's on the drawing board right now.

**Patrick: I have a question for you?**

**Tom:** Yes.

**Patrick: Where is CMS with this though?**

**Tom:** Nowhere. I don't think that right now there are thoughts of reimbursing for this kind of care and that's fine. That's fine. Maybe they shouldn't be concerned with it. They should recognize the benefits of it. But maybe at some point more broadly the benefits come in the way of a tax savings.

**Patrick: We see with the balanced budget act that happened what, 21 years ago, right? So, what's happened over time for a lot of providers in the skilled space and also in the hospital world, the cost shift has been tremendous. So, they're saying something. They're saying take people out of these locations. So, on one hand, they're disincentivizing but they have no solution on the outside. And that's where I think there's a miss here.**

**Tom:** Yeah. I'm hoping they will engage at some point.

**Patrick: Yeah. Because I got to think it's modeled. You can model that.**

**Tom:** Yeah, of course you can.

**Patrick: And I think that that's where we have to start thinking about—because from an investor perspective and in the investment thesis would be. What you can deliver is a much better model just like Starbucks.**

**Tom:** Right.

**Patrick: Much better in terms of coordinating where delivery is.**

**Tom:** There's a question over there.

**Patrick: Okay. Sure. Go ahead, Bobby.**

## COORDINATION OF CARE TAX POLICY AND INCENTIVES [43:30]

**Bobby (audience member):** What's the potential that sort of tax policy drives some of this too, right? You mentioned the tax incentive issues, and you were talking about coordination of care ideas but more read perspective, right? There's a good reading and there's a bad reading. You've got to be careful of that. So how much of it is tax-driven? The way we think about healthcare and silos instead of collaborative. And is there a way to change it?

**Tom:** Good question. I'm hoping from a tax standpoint as I talked earlier that we will see some tax benefit for people taking themselves out of the Medicare system in a sense. Not looking at Medicare as the first step to address an issue but actually taking more responsibility and living a better life. I believe that good tax policy can help support this. Getting those who can afford this type of care today, to incentivize more people to do that. Because there are plenty of people that can afford to live in a more health and wellness setting that are choosing not to because I work my whole life, Medicare is going to pay for my health needs, they should see me in the emergency room twice a week if I don't feel well. That's my right as an American. That has to change. And I think there needs to be a recognition that a lot of the places

by which healthcare is delivered can be effectively owned by an institution like a Welltower because we are designed to own brick and mortar versus health systems that still own 100s and 100s of billions of dollars of real estate that they're not getting any return on. That is a burden. But I think oftentimes, as a tax-exempt issuer you think that your cost of capital is low and it could be in that, you know, might as well own real estate. I think these are big questions that are right now, I think for the first time in a lot of years being discussed. … There's someone back there.

## NATURALLY OCCURRING SENIOR LIVING COMMUNITIES [46:27]

**Audience Member:** … So, my wife's mom shows up last week and she has a broken foot but doesn't know it. So, we go and put her in a boot, and we threaten to take her up for six weeks to New England. And she convinces us, with her friends, that the ecosystem will support her in Florida better than sitting in our house in New England. So, my wife called me and was shocked. And I said, "Well, it's her choice, and she has a solution that we didn't know is there."

**Tom:** Yeah. Your mother-in-law has built a community. She lives in a naturally occurring senior living community that she has created herself. And God bless her. We'd have a lot fewer problems if more people were able to do that. But she's right. She's better with her support network.

**Patrick: The one in the back there? The back.**

## INCENTIVES FOR PREVENTATIVE HEALTHCARE [47:39]

**Audience Member:** Just curious, you mentioned at the beginning of your talk about how we're making healthy choices. So, what is the incentive now for preventative healthcare so that people don't end up with diseases that are a significant burden on the healthcare system? They eat better. They exercise. Are there any incentives for those kinds of programs?

**Tom:** Not many. And that's a problem. …

**Audience Member:** Because they're living longer.

**Tom:** Yeah, look, I think that clearly the program to stop people from smoking in the country worked. And the incentive was if you saw a parent or grandparent die at a young age and you became convinced that, that was because of smoking, you stopped smoking. But I don't think we have the proper incentives in this country to live a healthy life. You have to embrace that yourself because you want to feel better or look better. But I don't know where those incentives come from. I do think though certain cities—Mayor Bloomberg put calorie counts up in fast food. There's an incentive because you walk in and you think, you know what I feel like? I can have a cup of black coffee but maybe I'll have a Frappuccino today. And you look and you see the calorie count of a Frappuccino is like 900 calories and you say I'll have a black coffee.

**Patrick: Not going to happen.**

**Tom:** But before that, or you go into Chipotle. People think that's healthy. Chipotle's a healthy place to eat. A Chipotle bowl is 1,200 calories. And we think we're eating something healthy. So maybe it is if that's your only meal of the day. But until those calories were up there. You had no idea. You thought you were having a salad. So little things I think are changing behaviors. But I also believe that if you really want to change behaviors you've got to influence what's in someone's wallet. And I don't think we're there yet.

**Patrick: Any other questions?**

**Audience Member:** Over here. Over here.

## TRANSITIONING THE OPERATOR COMMUNITY [50:12]

**Audience Member:** Tom, your message is loud and clear that senior living is definitely part of the healthcare continuum. I think even through the actions in your transaction last year, you talked about negotiating. I can only imagine the conversations you have with payers in the systems. Talk a little bit about the operator community and what they're doing to kind of evangelize the same message.

**Tom:** Obviously, the operator community is very fragmented. This was an industry that started as essentially, a real estate play and one of the challenges of the senior living industry broadly, is that you have many of these companies that are still run by people who think they make money in real estate and not in care. And that's a problem. That's a problem and I think there needs to be a transition amongst the operator community to embrace what the business is because what was thought of as retirement housing initially, was built for places, for people who are very mobile and cognitive but might have been alone to live in a social environment. Again, it has morphed into private pay nursing. And that's a very different model. And I think a lot of operators do not know how to engage in the business in an efficient and cost-effective way. And that's a problem we see across the industry. And Welltower is doing what we can to try, at least, with our operator communities to change that. But you know I think that there has to be a transition in that sector, because it's a different business than most of the people who got into it thought they were getting into.

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