Vision: To fundamentally change elder care one family, one community at a time.

Mission: To provide comprehensive, high tech and high touch, non-medical and medical, at-home, person-centric, family-assisted, community-based, supportive living for elders and those with disabilities.
# We Are Living Longer

<table>
<thead>
<tr>
<th>Current Age</th>
<th>Life Expectancy (years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>65</td>
<td>21</td>
</tr>
<tr>
<td>70</td>
<td>17</td>
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<td>75</td>
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</tr>
<tr>
<td>80</td>
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<td>90</td>
<td>5.5</td>
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<tr>
<td>95</td>
<td>4</td>
</tr>
</tbody>
</table>

Senior Actuarial Table (Fidelity Investments)
23% of annual US ER visits are people over 65
Average Cost of each ED visit is $2168

43% of 65-84yo and 48% of >85yo in ED admitted to Hospital
Average Length of Stay in for >65 is 5.4 days at $2100/day

40% of >85yo and 30% of all hospitalized Medicare patients to SNF
Average Stay in SNF is 29 days costing Medicare $423/day

1/3 of Nursing Home admissions come from hospital, 1/3 from SNFs and ALFs, and 1/3 from home

- Congressional Medical Advisory Group estimates 60% of ED visits and 25% admission unnecessary if more home-based services available.
- Total healthcare systems savings estimated at 40%.
3% US ED visits are over 65 years old

3-48% are admitted to Hospital

0% of >85 yo and 30% of all hospitalized Medicare patients to SNF

0% of ED visits and 25% admissions unnecessary if more home-based services available.

Total healthcare systems savings estimated at 40%.
Where Do The Medicare Dollars Go?

The top 1% of Medicare beneficiaries consume 22% of the total spend, app. $98,000 per person per year.
Poor Care Transitions  = More Readmissions

Poor Care Transition Elements

- Issues with housing
- Prescriptions not filled
- No transportation for follow-up care
- Limited Support
- Low Health IQ
- Chronic medical and mental health conditions

- 20% MEDICARE PATIENTS READMITTED <30 DAYS = 2.6M COSTING $28B/ YEAR
- HOSPITALS W/ HIGH READMISSIONS RECEIVE REDUCED OVERALL MEDICARE PAYMENTS
Better Care Transitions
= Fewer Readmissions

Effective Care Transition Elements:

- Increased Patient Involvement in self-care
- Engaging family in transition
- Availability of medical and social services
- Communication between providers
- Medication reconciliation
- Delivery of DME
- Transportation ensured for medical follow up
At Home Support with Social Connections

**People**
Empowered members.
Doing for others.
Circle of Caring.
Reconfigured resources.

**Attitude**
Goals and aspirations.
Dignity of Risk.
Family, pets, interests.
Purposeful living.

**Technology**
Tools. Easy to use.
Affordable. Access.
Making connections.
Reducing loneliness.

![Diagram showing social connections](image)
Alone and Invisible No More


Allan S. Teel, MD