December 17, 2018

President Donald F. Trump and Alex M. Azar II Secretary of Health and Human Services

The White House, 1600 Pennsylvania Avenue, Washington D.C.

SHIFT (Self Health Insurance Funding Trust) THE PARADIGM TO WELLNESS

Mr. President, and Secretary Azar II,

My family and I want to thank you for the progress you have made in the America First and America Great Again campaigns. I want to add Make America Healthy Again to your priorities and agenda. The timing is perfect for your business acumen to solve the health care funding and quality problems that are endemic and exacerbated by the influx of Baby Boomers into Medicare and Medicaid … that will bring financing, using current inductive processes, methods and payment systems to their knees.

According to Secretary Azar’s published HHS strategy there is a better way, which will deliver high quality care at a lower cost:

• One of Secretary Azar’s top four priorities at HHS is to transform the American healthcare system, including Medicare, into one that pays for health and outcomes rather than sickness and procedures.

• The Secretary’s Senior Advisor for Value-Based Transformation and Innovation, Adam Boehler, has identified four areas of action for this agenda:

• Patients as empowered consumers

• Providers as accountable navigators

• Paying for outcomes

• Preventing disease before it occurs or progresses

Already under President Trump, HHS has:

• Saved seniors on Medicare $320 million in out-of-pocket costs in 2018 by reducing certain drug payments.

• Required hospitals to post their prices online.

• Allowed access for Medicare Advantage beneficiaries to a wider range of health benefits.

• Made changes to the Medicare Prescription Drug program to allow for greater use of low-cost generics and lower cost “biosimilars.”

• Proposed to level the playing field between different sites of care, to save seniors

$150 million a year on out of pocket costs.

**Our SHIFT the Paradigm program meets all of these principles and priorities plus removing all restrictions for preexisting conditions:** propose to implement the Enterprise Model of deductive processes to replace the Medical Model of inductive ineffective pursuit of treatment income for an illness, with a pursuit of quality of life outcomes for wellness. Payment should be for an episode not an esoteric diagnosis now used. We then can have integration of services through a continuum of care and interoperability of data for analysis. These policy changes will eliminate AARP’s estimate of $600 million in waste and my estimate of $1 trillion dollars lost to poor outcomes, declining national quality (America is number one in cost per capita and 32nd in quality) and the commitment by the Obama Care law of $1 trillion dollars to academic demonstration projects and another $1 trillion in enforcement over the next decade as the market is hit by the 77 million Baby Boomer tsunami. Even with the elimination of these mind-boggling costs we would still have an ineffective inductive system of health care and the lack of funding to meet the burgeoning demand. It’s time to modernize our health care delivery system so it improves lives and makes common economic sense.

The current culture is regulated and controlled by academic methods: The Medical Model = Population Health theory, the Accountable Care Organizations, Managed Care, Prospective Payment (PPS), Blue Zones, Health Maintenance and “pay to play” political contributions, all of which are inductive (input) principles not outcome methods. While the Enterprise Model = standardization of deductive processes and terminology to connect the continuum of care to outcome criteria and pay on that basis, holding providers to attainable budgets based on cost accounting methods for each episode of care. With economic incentives for compliance with maximum standards, accountability for quality, technological advances and cost effectiveness.

Our proposal is to assist the Bureau of the Budget and the Secretary of Health and Human Services with its assignment to replace Obama Care with a patient centered, a true and effective evidence-based system including economic incentives for prevention of chronic diseases and pay for results, and cost management tools. Replacing average rates and minimum standards that become minimal care for the maximum cost. I believe the Obama Care safety net for preexisting conditions could be left in tack but the “think tank” demonstration grants and regulatory enforcement policies using 16,000 IRS agents, that will cost $2 trillion dollars over the next decade, must be eliminated.

**Guaranteed:** Obama Care progressive and socialized thinking will bankrupt the Great American Enterprise. According to Obama his health care program wouldn’t cost one dime … he was right it’s costing Americans a trillion dimes. By the year 2020 no one will be able to afford the deductibles let alone the premiums. Also, Medicare For All isn’t feasible for the reasons given by the Secretary in his presentations. It continues the failed system of Government that takes away the best of Medicare and monetizes the health benefits when we need to establish economic incentive for each American to focus on their lifestyle habits for lowering the cost of health services. It changes the priorities from an external government issue to an internal personal problem for staying healthy. Where prevention and preservation are the basis for resulting economic incentives.

**The Problem/Solution:** As you know the Health care expenditures are 17.3% of GDP. Adjutant spending accounting for waste and ineffective management is another 23.7%. The dilemma is, there is no accountability or quality control in the current system for insuring results. We have a solution for the health care dilemma. Simplify and conquer … implement the Enterprise Model of deductive processes to replace the Medical Model of inductive ineffective pursuit of treatment income for an illness, with a pursuit of quality of life outcomes for wellness.

Yours very truly, All-American Care and Caregiver Management Systems, Inc., Jerry L. Rhoads, CPA, FACHCA, LNHA

PS: Attached are Exhibits A, B and C for use in implementation

**EXHIBIT A**

**EXECUTIVE SUMMARY**

SHIFT the paradigm to Health and Wellness

Mr. President and Secretary Azar, we must shift the paradigm from illness-based pursuit and payment for treatment to wellness based pursuit and payment for episodic outcomes.

**Our Proposal has the following five most important takeaways with this SHIFT in the paradigm:**

1) We put the authority and responsibility for wellness and illness where it belongs … with the individual. And gets Government out of the way of free enterprise, innovation and technology hindered by the regulators.

2) We put the responsibility for delivery in the hands of the providers who are accountable to standardized models of care and get paid for outcomes rather than incomes.

3) We base payment on output criteria such as a stroke (an episode of care as it impacts the 10 body systems) (not the current input averaging formulas such 77,000 diagnosis codes and population grouping for capitation).  This simplifies the process of moving to a problem-based system with coordinated solutions for the flow of treatment and rehabilitation outcomes.

4) We measure quality using standardized terminology and computer models to establish the continuum of care and expected outcome for each episode. Then analytics measure each providers’ quality and cost effectiveness.

5) We fund the wellness policies using a withholding system for each individual depositing say 6% of their paycheck into a Mutual Wellness Insurance Company that is used by the individual to decide who they select as their providers and how they invest their money for prevention, health preservation and if necessary, treatment.

I call this SHIFT (Self-Health Funding Insurance Funding Trust).  This will take at least a decade to implement but the biggest takeaway is the elimination of waste and ineffective delivery currently controlled by the bureaucracy.  And most importantly put the control and responsibility where it belongs … with the individual.  Then economic incentives can be used for staying well and avoiding chronic disease.

In summary what this does is gets rid of the exorbitant administrative costs of government and makes the providers accountable for results. The Consumer becomes the regulator. For the individual there is a focus on savings on the current overprescribing of prescription drugs and testing that isn't needed until the root cause of the body system problems are established.  For complete details see my book "The Boomers Are Coming" which establishes the reasoning and necessity of such a paradigm shift from input illness to output wellness as our society ages (primarily 77 million baby boomers).

So, what is the implementation plan for this dramatic solution? Can an entire culture (inductive infrastructure) be changed overnight before the current system goes bankrupt? Why not? It will take a change in priorities from a “money-driven” system to a deductive outcome-driven system that justifies the right amount of money to be spent. It’s neither a Red or Blue national health care plan. It’s an American Enterprise Health plan. Also, it appears that medical schools give lip service to wanting technology and transparency but supports no technology or computer-aided devices to convert guesswork to what best works for the patient. Current Computer Models exist for all elements of life and are utilized extensively to put a man on the moon, operate upon a heart, but no such models are used for restoring health and preventing the disease rather than reacting to an already acute active illness. Computer and artificial intelligence models exist for this purpose as well.

The formula is as easy as P.I.E. (Problem-Intervention-Evaluation). The assessment of the patient’s root cause body system Problems would be standardized based on empirical data about the patient’s history and health record used to focus the diagnostic process. Interventions are based on deductive assessment computer software systems that organize the inductive thought processes and focus treatment on the pre-indicated medical, emotional, social, and spiritual body system problems that each patient has … then evaluating results for payment and data analysis. we get to the root cause of the problem faster so it can be prevented and if necessary, treated. Once the deductive processes are focused on **P**robabilities, **I**nterventions so outcomes can be planned, **E**valuated, and measured the positive results are not far behind. Let’s call this the Enterprise Model of Restorative Care making the Medical and Social Models extinct.

What this approach does is utilize computer technology’s systematic deductive system … from the probability list of problems, a library of computerized possibilities are accessed to determine the approaches (medical **I**nterventions) needed to first prevent the illness and, secondly, to treat the problem, excluding symptoms from the process. Then clinical focus and efficiency rules the process, not a list of what ifs or could be’s. Most current clinical processes are based on cheat sheets that are glorified check lists and not focused on a decision (probability) tree using proven simple algorithms. Databases thrive on standardization and numerical outcome values for analytical purposes. Once we have the methodology established, the data can be captured and analyzed for improving outcomes predicted by the restorative models.

**Case management** that has been utilized for years in social service agencies and forward-thinking clinical settings is the perfect management context to utilize **P.I.E.** computer modeling activating problem-driven restorative processes. The benefit of case management is all resources are focused on restoring the patient, not on coordinating departmental information that may be irrelevant to the outcome being pursued.

**Cost management** based on the patient’s individual problems and needs reduces the overhead to get to an effective and efficient restorative and rehabilitation program. The use of computer models with minutes of care assigned to the interventions allows for a forecast (budget) of the direct labor absorption for each case. The roll up of this patient-related data provides management with a tool for scheduling staff by function for each day and shift. Efficiency and productivity are then measured in relation to the computerized models. This Activity-Based Costing system provides the Case Manager with a tool for staffing the caseloads and creating a framework for the accountability for controlling quality and efficiency. All ancillary providers would be networked into the case management file for each patient and only be allowed to fill doctors’ orders on the basis of approved standardized formularies for each care model. Any deviations from standard best practices would require approval of the Case manager.

**Quality control (improvement)** would be related to the goals set for each body system problem in the patient’s care plan. Achievable goals would be set by the models for each patient problem as a baseline unit of measure that can be easily quantified and tracked in relation to a body system problem, and program to validate and update the models. Improvements or changes in patient condition or declines in functioning will be inputted at the point of services using tablets, wall-mounted computers, or handheld devices. This the lowest level of care and cost available. It’s problematic/programmatic deductive logic connected to controlling quality, outcomes and costs. Thereby, eliminating the cost of wasted time and effort with poor results.

• **Physicians** • **Hospitals** would be reorganized into P.I.E. case management teams that would then focus on deductive prevention models and managing measurable treatment outcomes.

• **Nursing homes** would be reorganized using P.I.E. the same as hospitals. They are effectively geriatric skilled care hospitals anyway.

• **Assisted living** would be reorganized into case management wellness teams using P.I.E. restorative programming for assessed health and emotional problems to either prevent or manage the wellness process. Departmentalization would be discarded for wellness teams utilizing restorative computer models when health and wellness problems arise.

• **Home care** would be P.I.E. restorative care plan-driven, not treatment-driven. Teams would share in the recovery and “real time” data then drives the entire Restorative Business Model processes for the achievement of efficiency, high productivity, and quality focused on restoring the patients to their highest level of functioning for discharge to a lower cost/care model.

• **Hospice** would be utilized as an ancillary to the nursing home or home care based on the P.I.E. care plan only for the social aspects of a terminal disease. Payment would then be based on case managed outcomes, not treatments or medications or tests. Outcome measurement would be orchestrated by the P.I.E. care planning process.

How would this impact the current provider groups? Using episodic information processing they would be networked into and have access to standardized computer P.I.E. probability trees hyperlinked to body system’s diagnosis for performing assessments, creating care plans, and documenting interventions and outcomes. Confidentiality can be protected utilizing encryption. Payment is based on the episode carried out by the wellness teams supported by the standardized P.I.E. probability trees, care plans, and documented results of interventions and outcomes. Departmentalization would be discarded and case management restoration process with a discharge plan guiding the utilization of resources. Wellness management in practice would be based on computer-generated models for senior living and preventing chronic illnesses. With lifestyle habits being coached, not just put on a check list or dictated by insurance companies.

Payment would be based on the following for each provider group, including incentive bonuses for providers who discharge episodic cases to lower levels of care; plus, the number of successful preventive or palliative outcomes with the use of holistic and natural remedies with dramatic reduction in dependence on prescription drugs to promote wellness. Research shows that the reduction in prescribed medications leads to preserving health rather than just sustaining habitual use of drugs versus lifestyle changes.

* Hospitals: Payment per episode (Diagnosis Related Groups and Out Patient Payment rates replaced by P.I.E. Pricing) plus incentives based on number of recoveries by body systems, number of discharges to home by disease, number of restorative cases discharged to lower levels of care, number of successful preventive ER visits, number of successful preventive surgical procedures, number of successful therapy cases, and number of successful restorative nursing cases.
* Physicians: Payment per episode (Relative Value Units rates replaced by P.I.E. Pricing) plus incentives based on number of recoveries by episode, number of discharges to home by disease, number of restorative cases ER visits, number of successful preventive surgical procedures, number of successful therapy cases, and number of successful restorative nursing cases.
* Nursing homes: Payment per episode (Resource Utilization Group rates replaced by P.I.E. Pricing) plus incentives based on number of recoveries by body systems, number of discharges to home by disease, number of restorative cases discharged to lower levels of care, number of successful preventive ER visits to avoid re-hospitalization, number of successful preventive surgical procedures, number of successful therapy cases, and number of successful restorative nursing cases.
* Home care and assisted living: Payment per episode (OASIS rates replaced by P.I.E. Pricing) plus incentives based on number of successful prevention of readmissions to hospitals and nursing homes, number of successful preventive dementia procedures, number of successful therapy cases, and number of successful restorative nursing cases.
* Pharmaceuticals: The High Cost of Drug company R&D and underlying hospital services

As we research the success of drugs and cures the percentages are not encouraging for the health of Americans. Generally, the investment in drug R&D is for treatment not cure or prevention. As President, you’re right in trying to reduce the price of medications and the underlying hospital costs.   However, the true cost paid for the latest drug doesn’t focus on what will benefit the buyer, only the seller.

According to what I can glean from the internet, approximately 5% of the approved drugs are for unproven cures, 15% for masking the illness, 25% are better served by natural cures, 40% for placebo effect may be more effective, and the remaining 15% is anyone’s guess on what will cure the disease. No significant investment is made by the pharmaceutical industry nor the providers of care in prevention of chronic diseases or how to preserve a healthy immune system so the disease is rejected or accepted without drug therapy.  Our institutional researchers are pursuing prescription drug cures because that can be financed by the Government.  The outcome is chronic disease garners the funding and far out spends the search for preventative solutions.  A pound of prevention saves 40% of the $2.5 trillion cost of health care (or $1 trillion per year).

In reality, the most effective preventative drug is the American citizen’s personal initiative to practice better Self-Health habits. Preserving the human immune system and assigning that responsibility to the individual is the only long run way to reduce the runaway cost of health care.  And have the payment system pay for outcome results rather than scripts, treatment and doctors’ visits.  Our hospitals are currently the benefactor of illness not the curator of better health.  Then the nursing homes and hospice are the end of life treatment mentality utilizing drugs to mask and cover up chronic diseases.  Of course, the pharma co.'s are creating the long-term dependency on drugs that don't cure or prevent and have more harmful side-affects than do the diseases. And the life expectancy continues to erode due to opioids, obesity and the Baby Boomers unhealthy lifestyle habits.

The solution of course is for Medicare, Medicaid and health insurance to purchase an outcome not just be an income source for the pharmaceutical companies and health service providers. If the paradigm doesn’t shift to self-health (health care is a privilege not a right) for prevention and preservation of good health the cost of services will continue to escalate until we wake up.  It won't matter if it is Obama Care or Trump Care results must be the bottom line not just profits.

In my book “Restore Elder Pride” innovation focuses on a paradigm SHIFT (self-health investment trust) to outcome-based services not the current income incentives to keep Americans dependent on drugs, emergency rooms, hospital beds, nursing home occupancy and end of life care in an institutional setting.

**DEFINTIONS FOR CURRENT INCOME PAYMENT METHODS**

DRG’S … diagnosis related groups per patient day

RVU’S … relative value units per hour

RUG’S … resource utilization groups per day

OPPS …. Outpatient per visit

OASIS … Home Care encounters per hour

HOSPICE … Hospice visits per day

**DEFINTIONS FOR PROPOSED OUTCOME PAYMENT METHODS**

Funding the Enterprise Model is a withholding from each employee’s paychecks and deposited in their personal Restorative Health Account to be used for their personal payment to health care providers. (hospitals, physicians, therapists, nursing homes, home care nurses, fitness centers, wellness counselors) . therefore, it is each patient’s responsibility to hold providers accountable for what they are getting … then paying for results. Including results in an accumulation of substantial funds over a 35 year-work life and represents a savings account if a person’s health is well managed.

**ELEMINATION OF COST SHARING GOVERNMENT INTERVENTIONS AND REGULATIONS. THE ENTERPRISE METHODS ARE SELF REGULATING EXCEPT FOR RESTRICTIONS ON COVERAGE AND DEFINITIONS FOR TREATMENT, PREVENTION AND WELLNESS.**

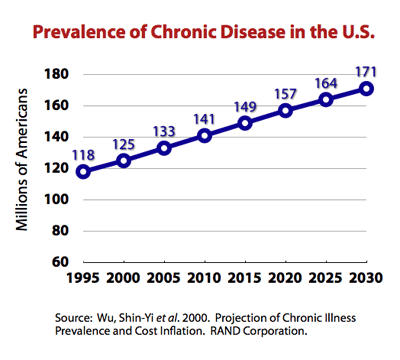
1. **No deductibles or co-insurance for patient participation**
2. **No restriction on days of coverage or denials**
3. **The only role of government is the requirement for employer withholding from employee paychecks paid to the employee’s account with the Mutual Health Insurance Company of the patient’s choice and the rules for what the funds can be used for.**

**EXIBIT B**

**Research Results**

**Why is this so important to understand …** *the more intelligent we are the more likely we will prevent rather than live with chronic aging.*Prevention is 9/10th of the solution and treatment prescriptions are 1/10th of the solution but 9/10th of the cost. Each of us must deal with the risk factors to make our commitment to living longer and chronic disease free. Rate your current age … you have two ages. First is your chronological age (birth age based on how long you **have** lived) and second your biological age (real age based on your current life style habits and a predictor of how long you **will** live).

Chronic Aging, life lived with a disease, is currently embracing 125 million Americans with its unhealthy lifestyle habits. Chronic diseases are the biggest threat to longevity. Stress is the cause of 40% of the Chronic Aging process. It is estimated that 61 million of aging American have up to five active chronic diseases. And they are being told by researches and medical experts that most are unavoidable and irreversible. Why? Because “Modern Medicine” makes its revenue based on this theory. Pills and treatment are the protocol. Clearly, 80% of the nation’s $2.7 trillion health care costs are attributable to chronic illnesses causing the chronic aging process.



“We are held hostage by the purveyors of complexity and freed by the genius of simplicity” Albert Einstein

* $14,662 is the average health care costs you could avoid if you’re fit. Stanford researchers who compared cardiovascular fitness of nearly 10,000 veterans to their medical bills found that the higher the veteran’s fitness level the less likely they were to have a costly chronic disease. Based on these numbers the likely average cost of chronic disease is $1,026,340,000,000 trillion for the 77,000,000 baby boomers in the USA.

Save it with the Enterprise Model for health care. Move from an inductive medical model to a deductive enterprise model. This will save wasted costs and improve quality.

**For example:** The Cook County Hospital now uses an algorithm based on three factors (probabilities) for directing ER patients with chest pain to the right alternative for care with 100% improved results over the prior list of what ifs (possibilities). Prior to using these 3 steps ,a 95% reliable formula, hundreds of patients with chest pains backed up in ER for days at a time . . . because the medical staff created a form with 100 different criteria to be checked before deciding to admit … after the 3 criteria (had they recently had a heart attack, what did the last EKG show and what was their blood pressure) patients were either admitted immediately or sent back home in a matter of minutes thereby reducing the backup of 100’s of cases in ER … a classic application of inductive health care costing time and lives. Ironically, this Inductive thinking permeates the health care profession … it’s typically treat, test and medicate before deciding the problem therefore never pursuing (formulating) an outcome.

**For Example:** Hospitals get paid a certain number of days of inpatient care by diagnosis code … an input criterion not output result. The stroke DRG 061 or 062 pays on average for 4.5 days of care (about $50,000) and they get the patients out to a nursing home in 2.5 days and keep the difference. Therefore, 500 DRG rates dictate payment. This has been going on since 1989 with the hospitals laughing all the way to the bank. Nursing homes, physicians, Home Care, Hospice all have the same leverage … no accountability and a cash cow for their owners. So, we ended up with fictitious prices … hospitals on DRG’s, Physicians on RVU’s, Nursing homes on RUG’s, Outpatient care OPPS, Home care on Oasis and Hospice on TCU’s. All based on the flawed strategy of minimal pricing for minimum standards of care and limited lengths of stay. When you use this complex approach for payment between the providers there is never accountability for a result and will never put an episodic connection between all the health care providers.

**For example**: Nurses are taught to do head to toe assessments on a daily basis on all patients to detect anything and everything that may happen. In our nursing homes we replaced this inductive thinking with

a P.I.E formula. Each patient had a profile of their **Pr**oblem-**I**nterventions-**E**valuation criteria that established a simple focus of care on their real problems not those that might happen. Nurse, physicians, therapists, nurse aides, etc. then dealt with known problems and solutions not speculation using up valuable restorative time. These are called care plans for directing and monitoring patient improvement or deterioration. They became the basis for managing the staff, costs and outcomes on an episodic basis for each case. Instead of using the ICD-10 code book of 77,000 different permeations (possibilities) of a medical diagnosis we used 10 body systems to trigger a likely problem list. Using computer modeling we then accessed the 10 most likely problems for ordering interventions and formulating the goals for improvement (outcomes) or preventing deterioration (also a positive outcome).

**For example**: A patient with a stroke, heart attack, cancer, diabetes or schizophrenia has 10 body systems that can be affected. They are Respiratory, Circulatory, Digestive/Excretory, Endocrine, Exocrine, Lymphatic, Muscular/skeletal, Nervous, Reproductive and Renal/Urinary. We simplified and conquered the confusion of inductive thinking using 10 systems probabilities. The current inductive health care system is utilizing 77,000 diagnostic codes based on symptoms in an attempt to determine treatment, tests, prescription drugs, and most importantly payment for services. While our system (Caregiver Management Systems) is managing the care of 10 body system’s problems with programmatic solutions not just pursuit of treatment and medications without a destination. Wasted staff time and ineffective guessing are eliminated and quality is a function of the problem, intervention and evaluation of outcome.

**CURRENT REALITIES:**

The following realities are extracted from my book (page 142 … “THE BOOMERS ARE COMING”) a proposal to SHIFT the paradigm from a Government Model to an Enterprise Model for our national health care programs:

Also, in our businesses, we owned three skilled nursing facilities and have consulted with over 140 that do not and will not make a commitment to modernize management systems or methods. Where is all this going to end? There are no flagships in the health care ocean, none on the horizon. Why? Is it because of a lack of spent resources (over $3 trillion spent annually) or is it a lack of vision that results in inductive rather than deductive systems and methods squelched under minimum regulatory standards dictated by the one buyer (government monopsony) market and bureaucracy.

As a CPA with my own accounting firm, it was never my intent to become a licensed nursing home administrator or owner. It was the pursuit of the idea that health care should be an enterprise model not an institutionalized model. The enterprise model would have a business base of quality, economic cost-plus margins to determine profitability. This base would be accountable to its market so quality is a measure of excellence and be the flagship for others to follow. I envisioned a systematic way to organize and manage health services as we do in all other businesses. This became an obsession to the point of no return … we started development of the standardized cost accounting system using computer technology in 1978 using tax shelter partnerships and venture capital raised for a return upon roll out of the system to our nursing home accounting clients.

That culminated in fashioning a franchise approach to ownership of the nursing homes. Thereby, putting an owner in the facility every day to insure compliance with maximum standards of care and accountable to their clientele not some government surveyor practicing health care without a license. Before we could build the three models using our technology and caregiver management system the surveyors were sent in to close us down … which they did with fines and threats (see my book “The Monopsony Game” for the details. So here we are pitching to you that idea.

In health care, quality is not a given and the fact that clinicians fight technology does not seem to be a reasonable excuse as to why it is too costly and inefficient. Who is paying the price? I feel it is the patient that pays the highest price … since 1989, using the diagnosis and symptoms as a payment system, it is estimated that 45% of the diagnosis codes chosen are incorrect … being chosen for bettering cash flow not best practices. There is just lip service to paying for results rather than fee for service and no strategies for incorporating prevention into the payment systems.

For example, my wife’s ninety-two-year-old mother was misdiagnosed as having Alzheimer’s and died from neglect and abuse in a nursing home and her sixty-six-year-old sister was misdiagnosed for two years as having arthritis when a simple early detection device called a CAT scan would have detected and enabled the surgeon to remove the Stage IV cancer that killed her. And to top it off my wife was misdiagnosed for years as having a nasal infection when in fact she had a congenital heart arrythmia problem solvable by an insertion of a pace maker.

Bureaucrats and the providers’ billers are making decisions on people’s lives because the Insurance Industry, Medicare and Medicaid programs cannot possibly fund their “pay-as-you-go” mentality. Long-term care insurance is being ignored by the younger population because Medicare or Medicaid will have to pay the bill. The “Baby Boomers” are expecting everything for little or nothing out of their pockets. Little does anyone know that we all must eventually pay the bills and suffer the consequences when the Government can now longer foot the bill.

Okay, these are merely my opinions about the symptoms. What is the real problem? We are now in the new millennium and still trying inductively to organize the existing information into manageable processes … processes for organizing and directing the thought process of the clinical professional to pursue preventative and/or treatment outcomes.

This is not computers practicing medicine; it is higher archival systems organizing medicine into a deductive model for the holistic purpose of prevention and treatment of acute and chronic illnesses. This should do away with the costly wasteful inductive work flow that does not matter and focus on plans of care that pursue logical outcome-driven interventions and goals. It is also a risk management method to avoid wrongful death suits and frivolous contingent liabilities.

**THE LAST WORD** (page 301 of the book “The Boomers Are Coming”)

ANALYZING THE LIST of the 100 oldest people in the world and the profiles of the Baby Boomers demonstrates the differences in the life styles of females versus males. There are only 5 males on the list of the 100 oldest and other 95 are females. Not surprising if you go into a nursing home and see mostly females. However, we also realize that that mix is changing every day due to the changing culture for men and women. Smoking or not smoking and stressful living or not gainfully employed are probably being the most significant factors. So, we need to benefit from what we have experienced:

• Stop smoking Start deep breathing

• Stop sitting Start getting out of the chair

• Stop gripping Start finding your talent and a job

• Stop Bidding time Start yourself on a mission

• Stop procrastinating Start your venture

• Stop worrying about money Start planning for another career

• Stop Riding rather than walking Start an exercise program

• Stop being negative Start meditating on happiness

• Stop Killing yourself Start living longer and better

Our society does not move its brain and body enough. It is showing in the numbers of over-weight people but more importantly it is permeating to our youngsters. No longer do we have a lean and mean look to our youth . . . also the work ethic seems to be different . . . the values are

different . . . the foul language has escalated . . . the use of texting, sexting, videos, violence, porn, teen pregnancy, drugs, alcoholism, etc. are all signs of a deteriorating society. Is all lost? Hell no, if we decide to make changes in our social mores, habits and values . . . our leaders need to emphasize this, not fighting about issues and dividing us on social problems that the constitution has already decided:

Health and welfare of the citizens are not a right but a privilege under the Fifth and Fourteenth Amendments that states each individual is free to choose their life style and are responsible for their own health and welfare needs All is lost if we are not dealing with social problems that need to be addressed, not with more laws, but with leadership initiatives:

All too many people take our great country for granted and expect someone else to make the decisions on their lives . . . not good . . . that is the way democracy is replaced by Government for socialistic reasons that are in reality an erosion of our individual freedoms as stated in the Constitution. We are at a juncture in our history where the individual needs to be the focus not the greater good . . . we all must take responsibility for our own future, wellness, standard of living and happiness. And elect leaders who believe in the enterprising nature of Americans that is being quashed by too many laws, law makers and money driven values. If we are not willing to stand up for our country we are willing to fall for anything proposed by a few control freaks. Not good!

**EXHIBIT C**

**CONSULTANT QUALIFICATIONS**

We used our Caregiver Management System principles in the nursing homes we consulted with, managed or owned. We took despicable nursing homes and either assisted or managed them based on 12 aspects of our programming to restore functionality and cognition and rehabilitate patients’ physical and mental capacity to enable them to return to their families. If they had to remain in our facility their quality of life was ensured by these 12 principles (habits) of life. As a result, we were able to restore and rehabilitate 43,500 patients back to their families, homes and communities. The following 12 principles of care were used in implementing our caregiver management system in over 140 nursing homes:

1. Think Young, look younger

2. Regular (often) personal encounters

3. Have a purpose and play games

4. Health and Happiness activities (gardening, home visits)

5. Family and friends visiting

6. Regular physical or mental exercise

7. Cleanliness, less stress

8. More positives, less worry

9. Better food, less calories

10. More sleep and dreams

11. More hobbies and activities

12. More prayer and beliefs in self

My wife and I are preeminently qualified to provide consultation on how to implement the Body System P.I.E. Deductive System on a global basis.

Jerry L. Rhoads, the author of “The Boomers Are Coming” (Xlibris 2012). This is a “Third in a series of Self-Health books” that promote wellness through personal fitness and commitment to disease prevention and health preservation. He is a graduate of Simpson College, a CPA, FACHCA and licensed administrator. He has extensive experience in all facets of healthcare. He was a health care consultant at Arthur Andersen & Co. that helped implement Medicare and Medicaid in hospitals, clinics, nursing homes and long-term care campuses. He is licensed as a Nursing Home Administrator in multiple states. Previously, he and his wife and son owned three skilled nursing facilities and managed many more. He has invented, with the help of his son, software for episodic care planning, costing and managing the restorative processes for the elderly so they can be returned to the community. Jerry lives in Chicago, Illinois with his wife. They have four children, 12 grandchildren and 3 great grandsons.

He was previously a consultant to Faye Abdellah, R.N. Assistant Surgeon General of the USA. He wrote the white paper for her and the Department of Health Education and Welfare in 1977 establishing these methods in his books. Ironically, though embraced as the solution, the academics from Eastern Universities prevailed making it administratively simple using flawed regression computer analysis of past Medicare billings and cost reports to base future payment rates on inadequate averages with no relationship to current services rendered so they could control the costs.

In my book “Failing Government Taketh Away” (Xlibris 2013) I propose these changes and how episodic payment can evolve into privatizing a national health care program where the patient controls their own money for prevention, treatment for body system problems and preservation of their health. This is called SHIFT the paradigm to a **S**elf-**H**ealth **I**nsurance **F**unding **T**rust whereby each working American has a withholding account with a Mutual health Insurance Company and they decide how to spend it and how to save it. It works on the fact that moral incentives don’t work and economic incentives do. The withholding accounts would be managed by each American through a mutually owned Health Insurance selected from a directory of private companies, eliminating the waste and abuse of benefits by State and Federal government. The insurance industry would continue to be regulated and held accountable by the bureaucracy. But now the patient is the overseer of quality and outcomes or they don’t pay. The regulated reserves of the not for profit mutual health insurance companies would be reinvested in technology and growth to meet the demands of America’s aging population.