PRESENTED TO:

DATE: September 8, 2020

PROJECT:

STATEMENT OF NEED

To assess the current operational health of through discovery, observation, and review of team communication and organizational business process. The scope of work will include:

1. Department head/key facility leadership interviews and scope of work review.
2. Regional leadership interviews on facility standing.
3. Review of facility key performance indicators in operational, clinical, and business development categories.
4. Identification of immediate areas of opportunity for enhanced performance.
5. Provide recommended action and supporting tools to drive positive performance.

GOAL

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Provide baseline analysis of to serve as a catalyst for strategic business change. The intention is to provide a recommended foundational framework for enhanced competency, output, engagement, and performance norms for the center.

This engagement is a qualitative intervention. The opportunity for stakeholders lies in embracing the narrative, which means appreciating and accepting the trends elicited from the subjective realities presented and embarking on a journey for corrective action and innovation.

OBJECTIVE

To position with both short and long term gains in operating performance through the delivery of a comprehensive recommendation on critical indicators.

METHOD

Employee responses and organizational data were analyzed to identify common patterns and trends within the organization. The trended perceptions/assumptions along with gap analysis, represent the implicit culture, e.g., operating norms. The emerging inherent culture was analyzed with current theory to identify critical environmental processes within the organization that impacts positive performance, as understood by this specific leadership population within the context of long-term & post-acute skilled nursing.

The team dedicated time to Everest that spanned over multiple weeks. Each team member that we completed sessions with displayed a solid foundation of industry knowledge and focus areas for the center. That being the case, it is important to state early in this document that most of the recommendations provided will come in departmental efficiencies. Efficiencies that will help each discipline work more cohesively and remove areas that delay work and prevent care quality. You will also find a recurring recommendation for the regional leadership team to take a root cause analysis approach with department leaders, suggesting a side-by-side performance improvement methodology versus top-down approach. The center appears to need more leadership hands versus leadership accountability.

The feel of the department head team at is a group that is often surrounded by regional and organizational leadership. All department heads seemed to know how to answer our questions expertly and portray their disciplinary elements without creating an alarm. Everest assesses that this is an opportunity for the region team to dive more deeply into essential areas to break through the quick answers provided and the department head's professional abilities to articulate disciplinary knowledge. Everest validated this by requesting secondary sessions with multiple department heads. These sessions are where the opportunities for specific support emerged and where Everest formulated many recommendations.

Everest assesses that the new center leadership team has the knowledge, skills, and abilities to make significant strides forward. Each leader appears to come with unique skill sets to accept the challenges they face within the center. The department heads also show as committed to the center, dedicated to the time that it takes to be successful, and urgently seeking an environment that allows both vision and direction cross-functionally.

is new to the NHA position at and has recently become a nursing home administrator. He has created quick wins and preliminary plans to correct elements that he perceives to be critical to performance success. These vital areas lean toward the clinical department, which is where is most comfortable. This preference is expected with his newness in operations licensure. That said, he has significant room for improvement in traditional NHA operations understanding such as expense control, labor management, rate management, and NOI.

speaks with ease when discussing his team and the dynamics within the group. He appears to know his team and understand their work styles. Conversations regarding clinical issues such as discharge planning and unplanned hospital discharges were comfortable topics for . He was able to identify areas with opportunity for improvement and to discuss interventions tied to clinical components that the team is implementing to address. However, once the discussion turned to operations topics, became visibly uncomfortable. He was unable to answer questions regarding his budget and could only confirm that the center has a budget and that he has access to it. However, beyond his confirmation of the budgets' presence and its accessibility, could not easily discuss the details of the items that shape his operational strategies.

surprisingly didn't navigate sales discussions as easily either, but this appears to be due to his lack of involvement in the sales process since he has joined the team. He did not know who his dedicated sales liaison currently is, giving the name of an individual soon to start;

and made several comments about being unaware of the current sales activity related to the barriers that COVID presents to the sales process. However, when asked how his referrals were currently received, there was confusion around who his resources were and whether or not they were dedicated to him or had multi-center responsibility. Either way, it was clear that he does not have much contact with the external liaison team.

Everest recommends that each liaison responsible for referral generation has dedicated center business development discussions every month at a minimum. This meeting aims to build a relationship with the team outside of the admissions department, allow the liaison team to become familiar with center enhancements and positive clinical outcomes, and ensure clarity of liaison role and contributions.

When the discussion moved to support provided by the region team, talked explicitly about the difference in direct operations support availability compared to other organizations. He not only felt comfortable going to and his regional team for assistance but felt the region team was independently interested in the center's success. and providing reliable operational support was the genuine perception from all of the team. However, as stated earlier, Everest assesses that the regional team could go more in-depth with each department head in solution creation and actual direct center assistance for performance improvement. The region team's ability to incorporate creative brainstorming and direct assistance with department leaders to find the best improvement scenario will be extremely valuable as compared to Q&A style leadership.

As we toured with during the virtual tour, it was evident that he is well received and well acquainted with the staff. He interacted with team members during the tour in a way that showed both the respect he commands from the team and intimate knowledge of the daily operational flow of the facility.

The center has a clinical department forced to function as both clinical and operational leadership. This functionality is not due to a lack of engagement from the NHA, but a result of the patients' elevated clinical complexities. As a result, most questions appear to land with nurse administration because newness to the NHA position does not give him the ability to have quick solutions to problems. Subsequently, the partnership between the DON and ADON is a winning combination. It seems to allow for regional level results orientation from the ADON to layer in with the DON's creation of clinical department accountability and culture.

As all are aware, there has been a changing of the guard related to clinical leadership. The transition of the former DON, who had a solid performance record but lacked consistency in process, structure, and root cause analysis, has tainted some of the remaining clinical team's perspective of the new DON's leadership style. is perceived by Everest to be a personable yet strong leader who inspects her expectations and is attempting to hold people accountable for their roles and responsibilities. This transition of nurse leadership appears to be the cause of current retention issues. As a result, Everest recommends more formalized discussions with the current clinical team members around past performance, current trends, and future goals. Goals that each clinical team member contributes to and that leadership looks at to move initiatives forward. Ownership in goals and rewards tied to small wins will go a long way at this facility.

A focus on nurse administration should be an organizational strategy for All unit managers are new, and Everest recommends formalized team building alongside goal identification. The goal would be to begin building team culture around requirements and shift the perception of work away from a feeling of "heavy loads" or "staffing shortages." This step will help position short-term clinical outcomes and long-term staff sustainability due to purposeful work.

Everest recommends this work as an enhancement to the daily morning meeting agenda. Everest had an opportunity to participate in meeting virtually. It lasted 20 minutes and was light in operational review for size and complexities. Our participation in a "quick" 15-minute meeting could have been designed for Everest uniquely - to show a concise and not time-consuming start to the morning; however, it lacked expected and standard review components such as:

- No review of grievances
- Limited returns to hospital discussion: Occurrences were reported but without any review or discussion
- No discussion around scheduled care conferences for the day - all floors
- No review of Ambassador/Angel round findings
- No review of At-Risk residents and needed interventions
- No review of completed non-clinical Stop and Watch forms
- No review of facility rounds
- No labor review
- Limited IDT discussion around a reported incident (discussed that a resident fell but no discussion or recommendations for intervention occurred)
- 6-8 nurses in attendance: Everest questions if this is necessary
- Laptops were not utilized by anyone in attendance
- Admission discussion was just a number of admissions expected, no discussion of special equipment needs or patient specific information.

General impression of the morning meeting was there was no outcome focused discussions based on the information presented. As a result, the meeting did not drive accountability for the teams' adherence to standardized processes or the execution of action items. Everest recommends the immediate utilization of a standard morning meeting tool that includes the above areas. If this tool is available, Everest did not see it being utilized or completed during the meeting.

Revenue Generation:

Accounts Receivable:

Business Office Manager has held this position since November 2019. Previously, she served as a Medicaid financial screener for Genesis and as a regional Medicaid expediter for Communicare. At she is primarily responsible for census entry, cash

posting, Private Pay collections, creating and reviewing (but not sending) 3rd party claims, charge keying, and various other business office tasks. Everest recommends that utilize Shannon as a Champion to assist in operational understanding, revenue capture, and financial performance strategies.

The facility has an aging balance as of 6/30/2020 of $6.785M. $1.3M is over 210 days old. Since 4/30/2020, the overall aging has grown $168,000, and the over 210 has grown $282,000.

The largest areas of concern are:

1. Medicaid Pending: Overall, Medicaid Pending (all pending payers) is $1.534M, with $308,000 over 210 days old. Growth in pending between 4/30/2020 and 6/30/2020 is $356,000. We subsequently spoke with , who let us know that over $700,000 in Medicaid Pending has been approved in July and will pay in July and August. This collection will considerably improve this aging bucket to include over 210. Excellent work for the department.

2. Medicaid: Overall, Medicaid, including hospice and co-insurance, is $2.229M, of which $303,000 is over 210 days old. Non-Co-insurance Medicaid has gone down between 4/30 and 6/30/2020 by $650,000 ($63,000 in over 210), representing a significant improvement.

   Co-ins Medicaid has increased over $172,000 during this same time, with over 210 increasing $64,000. Medicaid Coinsurance is a major factor at this facility.

Everest recommends that the center identify and perform Medicare Bad Debt Write-offs of all appropriate Part A Medicaid Coinsurance balances. DC Medicaid pays the coinsurance in full, and most balances are under 120 days old. MD Medicaid usually ends up in Medicare Bad Debt**.**

3. Emphasis needs to be placed on making sure the appropriate Remit is available for performing the MBDWO.

4. Part B Coinsurance is at $129,000. This bucket needs serious attention from a billing and collection standpoint. These are generally small balances and can often fall off the radar during reviews.

Private and Patient Liability:

Overall Private Pay/PL (including Co-ins) is $1.046M, with $538,000 over 210 days old. This figure includes PEME plans, which presumably are paying monthly. These buckets have decreased by $12,000 since April; however, the over 210-day amount has increased 180,000 over the same period. This increase implies the center is doing a better job of collecting early money, but have lost sight of balances as they age out. indicated that she has support from the corporate attorney for asset searches, legal collections, etc.

In addition to continued corporate support, Everest recommends establishes a collection protocol that requires collections letters be sent on the 5th business day of

delinquency. A second letter on day 10, 3rd letter on day 20, and final/DC letter (where appropriate) on day 30. Shannon indicated that no discharge letters for non-payment had been issued since she started in November. Further recommendations include:

1. Consider utilizing an outside collection agency for problematic accounts.

2. At the earliest point of Medicaid Pending disapproval, move the balance to private where appropriate.

3. File estate claims at the earliest possible opportunity.

4. W/O any accounts where collection efforts have been deemed impossible/unlikely as soon as accounts are fully reserved for bad debt.

Rates:

Based on the financial reporting we received, the document does not separate by payer types to coincide with the financial statement revenue break out. Therefore, Everest is only able to find the $PPD revenue for Medicare days and overall days.

For YTD May 2020, maintained an average daily Medicare rate of approximately $617.

However, this amount is high due to the increased revenue for COVID patients. We do not have the breakdown for the number of the COVID Medicare days, but it had a drastic impact on Medicare rates for YTD May 2020.

From a total census day perspective, has an average daily rate of $427. This rate is due to a few main factors: COVID Medicare days and the high number of vent and trach patients.

After a review of the rates for quarters ending December 31, 2018, it appears that the CMI% is decreasing. From 1.47 during the first half of the year to 1.38 for the 2nd half of the year, the decrease in CMI is anticipated to negatively impact future Medicaid rates.

Due to the high acuity, we would expect the Medicaid rates to be significantly higher than the state average for Medicare (vents and trachs) and Medicaid (based on tracking the CMI). They are currently above average in DC, but feel that based on their high level of acuity, the CMI could be higher if they were able to capture all of the care provided.

Everest recommends a CMI audit to ensure all appropriate captures are occurring.

Medicaid Financial Review process:

Shannon has a wealth of knowledge regarding the documentation and financial review process for prospective Medicaid LTC residents. Shannon indicated that DC Medicaid approves typically within 60 days; MD is longer as they tend to be more stringent in their review process.

Given the considerable balances in Medicaid Pending, coupled with Shannon's full understanding of the process, Everest recommends that Shannon be inserted into the financial review process ASAP in the pre-admission process specifically when red flags arise with potential admissions.

A/R Reviews:

Shannon indicated that weekly A/R reviews occur with . Monthly reviews occur with the whole team, including the administrator.

Everest recommends that with $1.3M over 210 days, all parties become educated on the Bad Debt process/status as part of the monthly review.

A secondary recommendation is that deliverables regarding top collection accounts for all payers should be clear with specified dates for completion/update assigned to all team members as part of the weekly/monthly reviews. Regional management should participate in the monthly review as well.

Business Office Staffing:

is a very large, high volume SNF with significant Quality Mix and census variables.

Everest strongly recommends the addition of an assistant BOM. This will provide more focus on private collections and Medicaid Pending cases that are bogging down the A/R. The reduction in Bad Debt through enhanced Medicaid Pending approvals would easily pay for this position.

Financial Review:

is a relatively new administrator and could benefit from coaching and tools to better understand and prospectively look at the facility's financial performance.

Everest hosted a quick financial review session with and to review financial knowledge more thoroughly. While there appears to be some review of revenue and expenses monthly between and the corporate team, it is more of a drive-by than a deep-dive into the financial statement. For example, is aware of an expense overage but could not explain the expectation to analyze or utilize the knowledge to chart the course for improvement.

It was also shared that the team is not required to discuss rates, stating that when revenue is down, the team knows it is a result of the census. This statement mirrors the approach to revenue generation being tied solely to census days. Everest recommends that all NHAs participate in training sessions designed to understand rate management with all payers. This training will be key in the appropriate analysis of center revenue opportunities.

The same recommendation is true for PPD management at . While they have PPD listed in their office budget, if PPDs are not met, is not required to create an action plan to improve. needs assistance in understanding how to analyze and utilize PPD within the operation.

The accrual or bad debt process is handled by the corporate office in , indicating that the center team is not involved in accruals. However, in the financial statement review, it does not appear that the corporate office utilizes accruals appropriately. stated that if expenses are off, it could be due to a bill from the previous year.

Everest recommends that the center utilize a process to include facility employees, to accrue for expenses, and recognize expenses in the correct month. The addition of a center and organizational KPI report to assist NHAs in understanding their performance successes and opportunities is also recommended. This tool will allow NHAs to focus time on the areas that would have the largest impact on the operation.

Lastly, Everest recommends that a training plan is created for focused on understanding variance reporting, enhanced P&L review, and a formalized departmental spend down process that could be used throughout the month to keep a better eye on expenses as they occur.

Rehab Department:

The department has 26 therapists per the center's program manager. With a Quality mix of approximately 70 patients, coupled with a robust Part B caseload, it's premature to determine if staffing is too high, but it appears that way on the surface.

Additionally, if the facility hopes to foster better relationships with Managed Care payers and hospitals, the Rehab staff has to be more Length of Stay motivated. The current Medicare LOS is approximately 30, which is significantly higher than national and regional averages.

Everest Recommends a review of service efficiencies to determine Rehab department staffing level appropriateness for the facility. Education and Training on Medicare skilling criteria related to rehabilitation should be performed for decision-makers in the Rehab department to drive appropriate Length of Stay. The rehab department is still leading Medicare Length of Stay discussions. With appropriate utilization of the PDPM consultant notations, a strategic approach to increase clinical ownership in case management and LOS should assist in rate capture.

Rehab efficiencies will be discussed further in the clinical portion of this document.

MDS Department:

The MDS department is staffed with four people, which would seem to be an appropriate number given the high volume of patients, admissions, and discharges. The facility is in the process of hiring a new MDS department manager. We spoke with the three current staff members. The staff is well organized and is current with the MDS schedule.

In setting the MDS schedule, the staff rely on obtaining clinical information from the hospital to set the assessment date to capture services performed in the hospital. The team is responsible for diagnosis coding, which is enhanced with codes from Rehab.

One common thread is that written documentation in the medical record does not always accurately reflect what the staff communicates to the MDS team. The team noted that "under-coding" of the wound stage on wound care patients was occurring by the nurses on the floor, resulting in QM scoring issues in the 5 Star rating. A recent change in process has occurred where the Nurse Practitioner is now doing the staging for these patients.

Documentation gaps lead to extra work in the MDS process, as the coordinators often need to re-assess the patients to gather the correct information necessary to complete the MDS.
In theory, the coordinator should review the MR and complete the MDS strictly from that documentation.

Everest recommends that all wound care staff be trained on and begin using the PCC Wound Care module. This module is available for use and comes at some cost to the organization. The module use would allow for accurate staging of wounds, consistent documentation, and mitigation of possible survey issues.

This recommendation's viability will be addressed in this document's clinical section, as the wound count within the center may prohibit appropriate utilization.

II. **Clinical Assessment**

The clinical complexities at reflect sub-acute and LTACH levels of competency. The clinical staff's demands and the reporting burdens of nurse admin can take away opportunities for employee culture, relationship building, and direct teaching on the floor.

The DON and ADON requested we combine their meetings, which worked well. Initially, Everest was hesitant to combine the sessions after being advised that the ADON was a prior corporate nurse. The team worried that would censor what she said with present. Our worries were unfounded as we identified early in the conversation that there is a genuine trusting relationship between the two nurse leaders. appear to share a commitment to the facility and share similar clinical goals. also supported fully during the call and seemed to believe in what seeks to accomplish as the new DON. did not portray a desire or struggle for power, which the Everest team suspected might be an issue considering her prior experience.

Concerns with safe staffing was a consistent theme throughout the interview, specifying concerns around staffing levels for direct care. They have identified inefficiencies within the department that contribute to employee dissatisfaction and takes staff time away from patient care. Top priorities assessed are the pharmacy process and the supply process. The center has access to a passport machine that packages the meds per shift and unit; however, there are only three passport machines. While the passport option appears like a pharmacy solution, there is an

issue with its inefficiencies with the medication pass process. For example, the nurses seem to have to return to the passport machine for all PRN medication requests. This requirement is an issue due to the center layout and the fact that it is not accessible on each floor.

A provided example of inefficiencies during a single med pass shows that a nurse cannot immediately give a PRN medication that may be requested. This inability is due to the nurse having to make multiple trips to the passport machine, preventing the medication pass completion. This additional step causes the nurses to pass PRN meds after the initial med pass. The PRN med pass can take up to 20 minutes to complete at a minimum if there isn't another nurse waiting for a med dispense. In that case, it takes longer.

Everest recommends considering the removal of PRN medications from the passport machine or adding a passport machine to each floor. Staff needing to move from floor to floor for supplies presented as an opportunity for efficiency, which will be discussed later in the document.

There does not appear to be much structure around core clinical systems. Everest also assessed a gap in the identification of outcome drivers for the department. Although both the DON and ADON were able to discuss the critical clinical systems, neither reported being responsible for those outcomes or provided a timeline for improvement. Everest recommends leaning on unit managers for outcome performance accountability.

Unit Managers:

The perception of unit managers' strength is two-fold. Some team members believe that Unit Managers at the center are not being helpful and over delegate tasks, while others believe that the Unit Managers are finally holding people accountable. Everest assesses that both are true and the below outlines focus areas to address. The unit managers should make a concerted effort to find side-by-side care delivery opportunities and return demonstration of expectation.

Direct discussions with unit managers showed that their focus is on supporting nurses identified as being burned out. However, while a good amount of time is working closely with the staff development coordinator during the on-boarding process, there was little training on how to work as a floor nurse. As a result, the Unit Managers lack confidence in alleviating the nurses' needs and overseeing the nursing functions because they do not know exactly how to fix problems that arise.

While the above is true, there seems to be a fair amount of experience with the newly hired Unit Managers. They have ownership in achieving unit success, respect for the NHA, and a feeling of empowerment by nurse administration. They appear to be very knowledgeable but cannot speak to the challenges faced on the floor. Unit Managers are not optimizing PointClickCare other than documentation focus and point of care. Training also needs to occur to strengthen the understanding of the standards of care process, precisely measurable quality outcomes on each unit.

Wound care is an example of this. The Everest and teams identify wounds as an area of focus for clinical outcome improvement. One unit manager could not speak to any process to manage and measure wounds on her unit. With the number of wounds in the center, this would be an expected metric for UM understanding and collaboration on improvement.

There is a perceived lack of accountability for the delivery of care within the UM position, and the focus appears to be on preparing for required meetings throughout the day. Everest recommends a thorough evaluation of the onboarding and training of nurses, and that the orientation begins to include the role of a direct care nurse and floor nurse responsibilities.

Areas of focus and consideration are as follows:

1. Poor utilization of PCC to manage clinical systems and prevent adverse outcomes.
2. Unit managers have a manageable assignment and are less impacted by workflow issues compared to other nurses in the facility.
3. Limited access to laptops to access PCC. Currently using desktop computers that have connectivity issues and routinely run "slow".
4. Staffing levels need immediate review compared to clinical acuity.
5. During orientation, unit managers are not orientated to the floor.
6. New unit manager has been employed 30 days and has never worked a shift on the floor.
7. UMs have a lack of awareness of nursing workflow challenges and workload understanding.
8. There doesn't appear to be a review of potential med/pharmacy issues beyond reviewing the newly input orders.

Wounds:

There are 157 wounds throughout the building involving 90 residents. Of those wounds, 90 are pressure wounds involving 50 patients. This situation must be corrected as quickly as possible to avoid the potential of receiving one or more IJ's during the survey process or before the survey if a family member reports a loved one's wounds to the state as a complaint. While many of the new residents who admit have wounds, the fact that the previous survey was deficiency-free indicates this situation is emergent. This indication will elevate the negative impact of survey, including civil money penalties daily going back to the first documentation of a facility-acquired wound.

The staffing model for this number of wounds should also be reviewed. There is one wound nurse who sees each patient one time per week over three days, completes all wound assessments for physician rounds, is required to hold all patients in position while the wound doctor dresses wounds, updates care plans weekly, and notifies the responsible party. This workload warrants an additional FTE to improve healing and prevent new wounds from forming.

While the facility has a wound doctor, who visits three times per week, a full-time wound nurse, and a nurse practitioner available, this number of wounds is beyond their ability to provide short-term support. The wound nurse appears to have a great relationship with the wound doctor. Along with the practice manager, she seems to be committed to and vested in the center's success.

The wound company offers wound certification courses that should utilize to certify more of the current staff, especially if this level of wound care persists as a clinical specialty.

The company also offers a large variety of in-services at no cost. has not engaged in this service within the past year. Overall, Skilled Wound Care (SWC) is an asset to the team. Everest recommends increasing the level of prescriptive dialogue and proactive engagement with the vendor. SWCs' service quality should be optimized to foster a strategic partnership that boosts the teams' wound care-acumen-skillset to generate positive care delivery outcomes and elevate clinical pathways to brandable clinical programing that drives business development alignments with progressive providers such as physicians or ACO networks.

Below are recommendations that can assist in both efficiency and patient outcomes:

- Complete a skin assessment on all current residents.
- Complete a skin assessment on all admitting residents on the day of admission.
- Request a multi-disciplinary care conference for each resident with a wound to ensure all areas provide support to the resident and the nursing department. Areas to consider including in the care conferences are: nursing, therapy, dietary, activities, social services, supplies, housekeeping, laundry, and maintenance.
    - Determine if the current wound treatment is working and the next steps in the care process to initiate or continue.
    - Update the care plan and all documentation required.
- Review the beds of all residents to determine if mattresses support wound healing to stage III. If not, purchase appropriate mattresses that provide wound prevention and healing support. Purchasing from one or more vendors may provide the opportunity for discounts based on volume. Lack of mattress availability was identified as an immediate opportunity by the wound doctor.
- Assess each unit for appropriate equipment to assist staff with repositioning and transferring residents from one surface to another. Staff should be able to find the equipment they need on the floor they are working. Lack of access to needed supplies and equipment is a significant barrier.
- Review the HPPD for all units initially based on census, but with acuity built- in to ensure each resident receives the support they need.
- Consider having all wounds in a few dedicated locations within the center to streamline clinical support and expertise.
- Develop approaches to use current software systems to track wounds and staffing to obtain just-in-time information.
- Develop a wound team to develop protocols to avoid wounds and heal wounds as quickly as possible.
- Investigate purchasing ultrasound to check for wounds beneath the surface of boney prominences before wounds appear.
- Investigate purchasing Doppler ultrasound to monitor blood flow through arteries and veins.
- Investigate ultrasound, ultramist, and other treatments for wound healing.
- The wound nurse should develop a plan of action to audit wounds and sound assessments to ensure all wounds are reported timely, and a plan of care is initiated.
- Attention to patients above certain weights to ensure timely repositioning should improve.

Weights:

Weights are not consistently completed throughout Given the acuity level of most of the patients, this would be considered a critical error and can result in receiving an "IJ" during the survey process due to residents being at risk for unsatisfactory weight loss. However, this could come to light sooner if a family member notices a resident is losing weight and reports it to the state. This is a serious situation that requires immediate action.

Recommendations are as follows:

- Weigh all residents immediately.
- Complete a multi-disciplinary conference for every resident who has lost 3% of their weight since the last documented weight check.
- Determine if the current diet is appropriate for the resident and what steps will improve the resident's weight, or decide if you can determine that the weight loss is unavoidable.
- Set up a routine weight program for all residents.
- Determine if there are enough scales to weigh all residents.
- Evaluate the types of scales available such as bed scales, lift scales, and wheelchair scales.
- Use PCC to develop a tracking system for weights that can be accessed daily, weekly, and monthly.
- Initiate training through faculty development regarding the importance of obtaining weights, accurately, documentation and how to report weights that are changed by 2% from previous weight.

Falls and Falls with Injuries:

Falls and falls with injuries is an area that aligns with wounds and weight loss in residents with co-morbidities, especially the residents that have admitted to .

Everest recommends the following:

- Develop a fall risk team to initiate facility protocols for falls that occur within the center. This team will be responsible for completing fall assessments, initiating a change in the resident's care plan, and completing required documentation. When a fall occurs, there needs to be a change in the care plan to initiate a step to decrease or eliminate the risk of falls.
- The fall risk team can develop a list of steps that can be initiated depending on the fall to guide nurses caring for the residents who fall.
- The fall risk team can audit falls moving forward to ensure falls are addressed appropriately.
- Initiate a training program for all staff through staff development related to falls, prevention of falls, and what to do when a fall occurs.

Staffing:

Based on the current outcomes, including wounds, weights, and falls, staffing needs to be reviewed to determine adequacy based on the acuity level of the patients living at now and for future admissions.

Everest recommends the following:

- Vent nurses should not split between two floors. Ideal ratio is 1:10.
- Review the current staffing pattern of each unit separately. Determine the acuity level of the residents who are currently on the unit and determine each resident's care needs as part of this process.
- Review historical staffing patterns to determine any changes
- Review national, state, and local HPPDs for nursing homes with similar acuity levels, including vents, trachs, diabetics, wounds, falls, dialysis, etc.
- Work with the staffing coordinator, unit managers, DON, ADON, and HR to develop a staffing pattern to facilitate the residents' appropriate care level.
- Review the wage analysis completed as part of this process and make recommendations for staff wage changes.
- Interview recent hires to determine their new employee training's success and make recommendations for future nurse and GNA trainings.
- The DON and ADON should develop an action plan to audit staff periodically and assess the staffing plan's appropriateness.
- Determine the appropriateness of having nurses on the weekend.
- Everest does not recommend 12-hour shifts due to the complexity of acuity.
- Sign-on bonuses for nurses in increments should be considered.
- Bonus for attendance should be considered.
- Bonus for employee referrals should be promoted.
- Consider a part-time manager as support for management team members who are on leave or vacation.
- Develop a dedicated center pool of staff who can float between units and shifts and potentially .
- Require part-time (PRN) staff to work one weekend per month and two holidays per year (one major holiday and one minor holiday)
- Use On-shift for scheduling. Require all staff to be trained on On-shift without exception.
- Consider short shifts for CNAs. For example, 6 am to 10 am and 5 pm to 9 pm. 1 FTE can be split to two part-time positions.

MDS Completion:

We are aware of the importance of completing each MDS within the required timeframe to receive maximum reimbursement for the care of the residents living in In addition to timely MDS completion, the MDS must accurately capture each resident's care needs based on each category's criteria. It appears they have the discipline within their department to drive outcomes but lack the tools and the empowerment to execute. Rehab has little involvement with driving these outcomes and typically responds to issues that the MDS flags. Unfortunately, responding in this reactive way and with this process prevents the facility from accurately reflecting the work they do to care for the patient.

The following areas are recommended for review to streamline processes within the MDS department.

- Delineation of duties does not seem strategic. MDS nurses, (3), divide assessments by resident location in the facility, not by payer.
- MDS nurses are not involved in the triple check and not familiar with that process. They state the regional MDS nurse performs those audits.
- There is no strategy for QMs. The facility is currently at a 3 star and they do not review triggers prior to completion of the assessment.
- MDS nurses go to the floor and perform wound assessments due to the high frequency of inaccurate staging and incomplete wound assessments.
- MDS nurses attend several meetings throughout the day that may not be necessary. A review of meeting requirements as well as figuring out how to get a QM outcomes process in place should become a top priority.
- The DON and ADON should develop an auditing process to review the MDSs periodically for timeliness and accuracy.

Staff Development:

The Education Department is an integral part of the nurse leadership team.
appear to work well together and have good processes in place. However, both nurses discussed that they spend a considerable amount of their time troubleshooting employee grievances, and there isn't a leadership process in place to manage grievances appropriately. They have earned staff members' trust upon hire, and as a result, the staff comes to them when they have problems. seem to triage everything from equipment needs to problems with paychecks or scheduling. This discussion revealed an opportunity for these nurses to take the data they collect from staff and put that through our QA process to identify trends. Again, the issue of supply availably was discussed as a significant issue, and the staff frequently have to spend excessive time during their shifts to access supplies, either getting to supply hubs or waiting on supplies in general.

The Everest team spent a significant amount on discussing staffing ratios. There is a perception that as a result of cuts made to direct care staff, the team that remains on the floor is not in the best position to provide quality care. This shortage causes turnover with newly hired clinical team members, specifically on the 4th-floor vent unit.

Everest recommends a corporate evaluation of the vent unit staffing models immediately.

Social Services:

is a regional employee who also serves as the Director of Social Services for the facility. Her regional responsibilities require her to float weekly between the buildings to provide social work support. is a capable social worker, but her inability to be on-site at or be involved daily in the center's patient management strategies have created silos

for each case manager/social worker. This schedule is considered a risk by Everest due to the size and patient complexity within the center. Each social worker/case manager operates independently without uniformity in process or expectations on execution. A social work leader who is present and communicating with the social work team each day would be a positive support strategy for the center.

In contrast to Everest's recommendation for more on-site support, specifically stated that she would like the company to embrace laptops and remote work for the social work department. She referenced wanting the opportunity to complete on-site assessments and then documenting off campus (at home). She feels that many of her duties are clerical in nature and that that facilities lack culture.

Everest does not recommend moving to a remote social work model.

Whatever option the organization decides is best, Everest recommends a joint case management meeting with the social work team to identify the departmental goals and expectations for 2021.

describes herself to work closely with the BOM, attends some care plans weekly, and shares the IDT vision to be clinically focused rather than interdisciplinary. She spoke to position on involuntary discharges and feels there needs to be empathy by admissions regarding the discharge process. She thinks that empathy in understanding what it takes to discharge residents who are nonpayers or difficult discharges due to life dynamics would allow them to "close the loop" on resident census and the residents on her caseload because they would better understand the situation.

The Everest team also communicated with , whose name was provided to us after requesting to speak with a social worker who is on-site daily. He appears to be positioned somewhat as a lead social worker, participating in the daily morning meeting, the daily clinical meeting, and the Managed Care UM calls. However, our session with him showed that he is a Mastered prepared social worker, with leadership experience from another center, but does not have the workflow knowledge of social work/case managers outside of his assigned vent unit. initially stated he was the one with the most management experience but went on to resist management level accountability to performance, both on his unit and within the center. When asked specifics about the care planning process and how he participates in the process, he did not understand the question, so we rephrased. He then explained that his care planning process revolved around an initial "7 day" care plan and a discharge care plan. He stated he did not see the value in other care plan meetings. When asked about advanced care planning, he was not familiar with the term. We explained and discussed the process of obtaining advanced directives through conversation with patients and families upon admission and throughout the stay; however, he seemed to have a lack of interest in providing bedside and hands-on services to the residents. He commented about budgetary cuts that have led to his heavy workload on several occasions, and that the workload is underneath his degree. He stated that he spends most of his time scheduling appointments and transportation.

also expressed concern with phone functionality and the customer service opportunities that it presents. He believes someone should be staffed on each floor to answer those calls and provide video chat sessions with residents. Each team member we spoke to has quantified phone

issues within the center. The staff does not answer phones, and they are not always working. This issue prevents communication with families and causes customer service failures.

Everest recommends the following to support the social work department:

1. A full review of the telephone process inefficiencies.
2. Consider hiring an hourly resource to own telephone management and assist with appointment scheduling center-wide.
3. Development of palliative care programming in collaboration with a physician to lead advanced directive discussions and help families and patients cope with condition changes tied to their diagnosis.
4. Immediate improvement in the advanced care planning process to include involvement from social services.
5. Immediate improvement in care planning practices with the center - specifically to begin having a 48/72 hour care conference for all new admissions regardless of payer source, adhering to the regulatory requirement tied to The Final Rule.
6. Require the Director of Social Services to be present at the center daily to guide the department's practices toward metrics of importance.

Scheduler:

is new to her position and responsible for the staffing of 5 floors. She taught herself how to use OnShift and, therefore, does not know how to benefit from its resources. This lack of knowledge causes her to utilize excel for paper scheduling due to ease of use. She is active in her daily labor meeting and works diligently to keep up with nurse turnover. She was able to speak to PPD staffing models but would benefit from utilizing a staffing ladder tool to assist her in reaching thresholds and staffing to acuity. She is committed to the center and is interested in finding ways to fill difficult shifts.

Everest recommends utilizing the center's OnShift contact to provide formal training on the system and suggests creating an acuity staffing model to better match the staffing schedule around residents' needs.

Activities:

The Activities Director is another example of the department heads having multi-center support responsibility and individual responsibility for their department success. The activities team has had to stretch their staffing model due to COVID cuts, which is also a recurring theme throughout the sessions. This department cut has occurred in what Everest perceives as the most at-risk area in the center if strong programming is not in place - the secure dementia unit.

Everest recommends dedicating one of the 4 remaining activities team members to the secured dementia unit to ensure appropriate attention and formal program training can occur. This dedication will improve the quality of life for the population within the secured unit, assist in de-escalating behaviors, and provide stimulation that will decrease wandering.

In addition to now splitting her time to cover activities on the dementia unit, the Activities Director also spends time partnered with HR to assist with employee engagement activities due to retention issues. Everest recommends the new HR assistant take on the responsibilities currently owned by the activities department to free up their time for resident engagement.

The remaining time spent on the floor by the activities director is with the snack cart. This time allocation is considered by Everest to be a missed opportunity for departmental efficiency as the snack cart transportation time to move from floor to floor after snack distribution takes 15 minutes at minimum for the elevator. Before COVID, an outside vendor managed the snack cart. Everest recommends the team consider allowing that specific vendor back on-site. This support will both allow and enhance one-on-one activities with patients.

Subsequently, Everest believes there is a constant theme of supply management inefficiency due to elevator slowness and lack of dedicated supply storage on each floor.

Central Supply:

The interview with the Central Supply Director confirmed this inefficiency. The director spends most of his time delivering supplies due to small supply closet capacity in the basement. While Everest recommends point of use storage, we understand that this is an impossibility due to storage issues in the center. However, a creative approach to supply accessibility will immediately improve nurse team time management and free up the central supply director to do more than hand-deliver supplies.

Everest recommends utilizing the director to root cause and create enhanced processes for supply and pharmacy efficiency. He has been a regional director, understands the LEAN methodology, and has created point-of-use plans for medication dispensing and supplies in acute hospital settings.

It is an immediate recommendation to find storage on multiple floors to decrease the time spent tracking down / delivering supplies.

Rehab Program Manager:

Everest's discussion with the rehab department manager centered on gaining an understanding of how PDPM has changed the utilization review and discharge planning processes within the center. Rahul quickly stated that PDPM did not change anything in his department related to treating patients and managing the team. He discussed the evolution of process changes from COVID and stated the only remaining restriction is that residents do not come to the gym for treatment; however, there are separate therapists for the COVID unit.

Everest is most surprised by the number of therapists in the department. Twenty-six people on his team, with twenty-four of them being therapists. Everest would have expected to see scheduling understanding; however, could not verbalize how he managed resources in his department and did not include any therapist productivity management discussion.

He did not discuss any length of stay management and appeared to focus on increasing the length of stay for managed care patients versus aligning quality outcomes with decreased LOS. There was a fair amount of conversation around how does not like working with managed care providers and thinks that managed care companies are trying to restrict access to SNF care for patients. He also expressed that managed care companies think SNFs are only trying to drain the insurer of resources. He has started "fighting back" against managed care providers, requesting longer stays for patients. He was proud in the fact that he has "won" some appeals.

Everest perceives this as a risk for managed care census growth and PDPM rate management.

Other restrictions with the rehab staff are that the team does not treat patients with wounds for positioning or any treatment modalities to aid in wound healing. They do not provide treatment for positioning residents in bed, only in chair positioning.

Everest recommends rehab participate in positioning, position training, and positioning checks within the center, given the number of wounds. This added support will positively impact the quality of care and decrease wound degradation.

Other opportunities of interest:

1. Point of use storage is a key issue for all departments
2. Movement of staff and patients throughout the center could be better organized (ie dialysis causes 65 patients to go down to the bottom floor 2 times a day for 3 days a week. Floor staff does this transport)
3. Dialysis provider is not collaborative with the center. The timely review of dialysis referrals is a barrier along with collaboration in communicating condition change for residents receiving dialysis. Improving this relationship should be a priority to decrease RTH and new admission response time.
4. Consider laptops for key clinical staff members (DON, ADON and Unit Managers)
5. On-shift is poorly utilized due to lack of buy-in from staff related to the key users not having sufficient training and understanding of system utilization.
6. PCC utilization is poor for several reasons. Lack of hardware, lack of clinical modules, and lack of training.
7. Lack of advanced care planning: The majority of patients do not have advanced directives. Most patients who expire in the facility receive CPR. 5 of 6 in facility deaths had in-facility CPR. Over 75% of new admissions did not have advance directives within the first 30 days of admission.
8. Clinical outcome management: does not appear to have a system to identify risk or mitigate risk to drive clinical outcomes in several areas.
9. Quality Measure Management: Similar to clinical outcomes, the facility does not drive QM outcomes. The team should establish a process to identify potential problems and interventions versus responding to issues as they arise.

10. Facility needs training with the IDT on how to identify risk areas in residents and how to address those problems to prevent a negative outcome.
11. Recruiting and hiring process: Hiring nurses who are not familiar with technology and possibly don't have the experience in an acute setting. Target to hire nurses with LTACH or Acute experience.
12. Lack of delineation of duties for all administrative nurses appears to cause multiple nurses to be involved in the same issues, processes, and systems. This lack of delineation seems to be leading to duplication of effort as well as incomplete work and ineffective outcome management.

Clinical Morning Meeting Observation:

- No one on the clinical team has a laptop open and utilized during the meeting
- There was no review of PCC prior to or during clinical meeting
- There was not an IDT component to this meeting it was nursing and social services only
- No labor or staffing discussion
- All unit managers remained for the entire meeting instead of discussing their section and exiting

Medial Director:

With being able to develop and accelerate relationships with referral sources for high-level partnership opportunities within hospitals and other provider networks, the need for the center to demonstrate its ability to achieve high-quality care is increasingly high. Physician engagement is a critical component of the teams' success in operating in such a complex care coordination and care delivery landscape. Everest believes that the patient population, market demand, and untapped potential for a more progressive SNF operation warrants an increased physician engagement to support in his efforts.

Conversations with demonstrated his commitment to the center. explained that he was in the center daily and that he was following most patients. With the utmost respect and appreciation of his willingness to assume such a large caseload, Everest believes that the center would benefit from additional physician support. In increasing physician engagement, the center can better utilize in more of the physician advisor aspects of his Medical Director role, such as staff education, clinical programming, and QAPI. Everest believes the center would benefit from the Medical Directors' increased involvement in an advisory capacity to help drive performance improvements on metrics such as readmission reduction. The volume of high acuity patients and the diversity in diagnoses result in Everest's recommendation to increase and diversify the center's physician support. The implementation of a specialist physician panel has the potential to positively position in the market as content experts in multiple categories of care. Additionally, introducing specialists will allow the center to have better outcomes by clinical categories and improve the management of the niche populations the team cares for, such as respiratory, nephrology, cardiac, etc.

Increasing physician support also directly affects the satisfaction of direct care with staff and patients.

During Everest's dialogue with the team, it was identified that a majority of the high acuity residents do not have advanced directives. When the Everest team asked about the reasoning behind the lack of advanced directives for the patient population, it appeared to be a gap in conversation and facilitation that could be improved by introducing a Palliative Care Physician to the team. The centers' current population warrants elevated discussion about disease state management to improve proactive care planning that guides the patient through the progression of their disease and supports them by setting expectations and optimizing life quality. Palliative Care Physicians can help the team shape the way the care planning occurs and help proactively mitigate risk for patients readmitting to the hospital and ultimately optimizing their quality of life. Overall, physician engagement is a strategy used to enhance the care delivery, patient satisfaction, regulatory compliance, and business development positioning, and the Everest team believes that the center would benefit from a higher-level physician engagement model.

III. **Business Development**

**In addition to this narrative, please see attached hospital patient movement data and coinciding executive summary titled Market Insights. **

Census Culture:

Everest's exploration of the center's business development practices began with a bit of uncertainty as the business development call was tentatively scheduled with the person who was believed to be the center's liaison. It wasn't until Everest's conversation with the facility's administrator in which it was revealed that the liaison was not yet hired and unavailable for the call. Additionally, it was to the NHA's surprise that the liaison was joining the team. During this conversation, the administrator informed the Everest team that the center has two FTE's composing internal admissions team, and at that time, the administrator graciously scheduled the Everest team to connect with the center's Admissions Coordinator and Admissions Director. Everest's conversation with the internal admission representatives was the point in which Everest became aware of the field sales structure being an account management model with multiple liaisons assigned to hospital accounts rather than directly tied to the center. This finding then led to Everest being able to schedule a call with the liaisons. The team's inability to communicate the department structure and its FTE allocation was concerning. Failure to convey the business development department's design and personnel dedicated to the center's census growth was the first experience that revealed the unstructured state of the center's business development function, gaps in the team's communication, and the absence of deliberate strategies for revenue generation. Overall, each conversation with the team bridged the gaps in Everest's understanding of the department's design and FTE resource allocation. Most importantly, the dialogue solidified Everest's belief in the team's potential for success and highlighted immediate opportunities for improvement.

Interviews with the team revealed a significant opportunity to improve the center's organization of FTEs, processes, goals, and the sales behavior necessary for census optimization. The team's demeanor and desire to do well was evident in all conversations. The consistency in the team's perspective of business development and high regard for census growth led Everest to believe that the barrier to their performance was the disorganization of their environment and furthermore, their approach. The center's business development team lacked a stable foundation. The subsection "Business Performance Management" provides details of the findings and recommendations for stabilizing the business development environment, standardizing expectations, and opportunities for the implementation of best practices that will position the team for success.

Irrespective of the collective positive intentions and agreement on the importance of business development strategy for census growth that was present in all conversations; business development appeared to be siloed and designated as the responsibility of the admissions team and external liaisons, rather than an accountability of the entire team. Everest believes the lack of consistent engagement from the center's team members is not due to laziness or disregard, rather it is a result of a lack of understanding of SNF business development and limited bandwidth. The team's uncertainty of what needs to be done, how to properly execute objectives, and how to manage their time, are perceived as the obstacles for interdisciplinary collaboration and the reason behind the silo. In addition to a lack of awareness and systems, Everest believes the business development function is siloed due to the insufficient engagement and support from leadership.

Conversations with revealed his aptitude in business development and general market comprehensions. Despite the NHA's awareness and skillset, it was clear that his involvement in business development functions were more passive and occurring at a lower frequency than both he and the team would like. Everest considers it a best practice for Nursing Home Administrator's to supervise business development efforts in order to guarantee the financial success of the center. It is recommended that the NHA oversees the admissions workflow to ensure that the right elements are in place to aid the team's efficiency and effectiveness. Additionally, Everest believes the NHA's market cognizance and management of liaisons as the external resources dedicated to the center's revenue generation as paramount to the center's business development success.

The suggested best practices for leadership involvement in business development were not perceived to occur routinely. However, it is important to note their absence is not a result of disagreement with the suggested level of involvement; rather, they are due to the NHA's need to respond to other more pressing matters on a daily basis. The same barrier appeared to restrict the DON's ability to more proactively engage in the center's efforts for census growth. Everest recognizes that the center's size, patient population, and current state of the industry, make it increasingly difficult for the NHA and DON to be involved with business development. Because of this awareness, Everest wants to emphasize that the suggestion for the DON/NHA ownership of business development is not for them to do the work themselves rather to maintain consistent awareness of the business development inner-workings to support the needs of their team and referral sources.

The NHA and DONs management efforts are about facilitating effective communication and strategic delegation to foster a more collaborative and streamlined business development

function. Their role should truly be leading and integrating non-business development specific team members into the formation of effective business development strategies. An example of this recommendation is the NHA and DON's ability to guide the information flow between appropriate personnel and the liaisons to solidify internal-external communication necessary to provide the liaisons with content for sales messaging and the center with information that crucial to their performance and care delivery fulfillment. Another example supporting Everest's suggestion for increasing the NHA/DON ownership and management of business development efforts, is their authority and ability to remove barriers and catalyze efficiencies necessary for business development productivity.

In such a large and busy SNF, it is easy to perceive "busyness" as a positive feature, however it is important to remember the difference in activity versus productivity. Everest's perception of the team was that everyone was working hard and maintained the best of intentions. When answering the Everest's team questions about their daily business development efforts, all team members made it very clear that they were busy, and Everest agrees the team is active. However, the activity is not systematic or strategic and as a result it is not as effective as it could be.

Increasing the NHA/DON involvement as leaders to oversee the business development function to optimize the team's workflow and facilitate the center's non-business development team members understanding of their role and contributions to census growth, are vital aspects necessary to improve the center's business development outcomes. Across the board, the team seemed overwhelmed in their roles and the daily operations. Everest believes this is due to the absence of a team vision for business development, the lack of census growth goals, and the missing systems, processes, and procedures to aid the fulfillment of the sales activity necessary.

- Recommendation: Utilize the Regional team to inspire the revitalization of organizational vision for business development and integration of standardized processes and tools as best practices that systemize the busy workflow into obtainable deliverables.

- Recommendation: Increase NHA and DON ownership of center's business development function to elevate overall census culture, marshal resources more effectively, and ensure cross-functional accountability to the objectives for census goal achievement.

The fulfillment of the recommendations for increased leadership support and the alignment and standardization of processes and tools, should resolve the workflow chaos and position the team for an elevated census culture and productivity. The claims and identification of the opportunities for improvement aforementioned are not only supported by the team's conversations with Everest but they are confirmed by the center's low conversion ratio. From May-June, lost 120 Medicare referrals to competitors SNFs. internal and external sales functions appear to be a haphazard and reactive, rather than a deliberate and manageable element of the business.

Overall, the market saturation, the center's ability to care for high acuity patients, corresponding potential for revenue optimization via PDPM rate maximization, and level of dedication from the center' team members contribute to Everest belief that the center holds potential to exceed current financial performance and lead revenue generation for the company as a whole. Because of the center's potential for success, Everest recommends strategically aligning regional team as field support for the center on a more frequent basis

in which the Regional team's activity is more prescriptive in their direct coaching and field support to positively position the center for success in their current state and design a plan for performance elevation and census growth in the future. The increased Regional team support is recommended to aid the center in the following aspects necessary for business development optimization:

- Catalyze census culture and cross-functional accountability to census growth.
- Support center leadership team to drive fulfillment of any specific target areas for performance improvement required for network inclusion or contract procurement.
- Reintegrate standards for business development processes/systems and tool utilization.
- Monitor growth goals and business development performance advancements.

Business Development Team Dynamic:

The current internal team dynamic between Paola (AC) and Andrea (AD) is positive, both ladies demonstrated their utmost desire and commitment to the center's business development success. The Everest team believes that both of the internal admissions team members embody the core characteristics necessary to be successful in their roles; however, it was clear that the ladies were overwhelmed and under supported by the unstructured environment. The center's intake process is reactive and inconsistent. The AC and AD share all accounts and referral platforms for intake management, there is not any clear designation of which internal counterpart a liaison should contact and vice versa. Additionally, the liaisons determine ownership of admissions preparation and the tuck in process based on availability rather than a systemized approach. The ambiguity in ownership of the detailed work associated with the intake process revealed an uncertainty in role delineation, and strategy for execution, thus compromising the team's efficiency and effectiveness. Everest advises designating role responsibilities and assigning the internal admissions team member's accounts that correspond with the liaison's accounts as a method to streamline the internal-external workflow and communication.

Formal direction from leadership and alignment of behavior-resources-processes will drive productivity and improve the center's referral to admission conversion ratio. Despite the internal admissions team's positive nature, high energy and commitment to get the job done, the conversations exposed the necessity to streamline internal business development activity and revealed the opportunity for continued talent development of both Paola and Andrea. Everest believes that both ladies maintain the ability to contribute more in their roles and have the potential to serve the center as internal sales professionals through elevated customer service as a conversion tactic. Because of their strengths, Everest recommends utilizing the AC/AD an additional layer of internal sales. This suggestion entails, the AC/AD as contacting the family members of premium payer referrals to offer virtual tours, answer questions, and ultimately serve as concierge like service leveraging excellent customer service as a conversion tactic.

Despite the positive dynamic between , and their individual strengths in their role, the center's current business development environment is not conducive to optimizing their performance or the external liaison performance. intake function is not

structured efficiently and should be redesigned. should be assigned accounts or referral platforms to streamline the intake process and reduce administrative burden in processing referrals as well as communicating with the liaisons more effectively.

Following discussions with the internal admissions team, Everest completed a session with the external liaisons. All liaisons were present except for . did not respond to the calendar invitation or text messages from his team during the call.

The external liaison team appears to have a command of the market with long term relationships within hospital systems. While this allows the team to navigate referral relationships easily, it has also created a barrier to developing new referral generation approaches. The following guidance should help revive the strategy for an increased referral generation and census growth.

Everest's conversations with the liaisons revealed a need for continued coaching and development of their sales acumen, product knowledge, and general business performance management. The group dialogue with the liaisons revealed opportunity for elevated coaching and field support to better hone their skills and identify creative ways to drive census during COVID. The liaison's explained that they have been assigned to work from SNFs rather than from home. Everest recognizes the logic behind having the liaisons work from the center and agree with the practice during times in which onsite activity is restricted. However, it is critical for the liaisons time to still be spent on business development specific work and for them to be more prescriptive in their efforts to grow census than ever before. Business development planning is essential for census growth in general, but its importance is increased during COVID due to the restricted access to referral sources and patients. The liaison team's business development approach was not very sophisticated as the conversations with Everest predominately circulated around their ability to appeal to referral sources due to their positive end user experience and surface level ability to articulate the center's general clinical capabilities. The liaisons were not able to expand on what the value of expedited response times and diligent follow ups meant to a referral source in terms of performance metrics such as length of stay (LOS) and its effects on the hospital's financial health. Nor were the liaisons able to expand on the value behind the center's clinical capabilities and reasons for designation as an ideal PAC provider or solution within the market.

The team was not able to have a high-level understanding of the significance behind referral trends or conversion ratios. The team was not able to answer Everest's questions regarding referral management or market share strategies. With approximately 30 to 50 referrals generated daily there are many opportunities for market strategy based on effective referral management and trend understanding. Everest believes the lack of awareness of the trends and dynamics of the current business is a result of poor time management, insufficient resource stewardship and ultimately deflated strategy for referral generation. Conversations with the liaisons lead Everest to believe that referrals were being sent to the center based on reputation and a general awareness of clinical capabilities.

- Recommendation: Define business development specific roles and responsibilities for

the liaisons, admissions coordinator, and admissions director. The role responsibilities should include self-study of their center's services/outcomes, the center's business trends, key referral sources, market trends and establishment of SNF specific referral generation best practices.

- Recommendation: Prioritize the talent development of the BD team.
    - Implement weekly coaching calls with liaisons to elevate their business acumen regarding product knowledge, industry shifts, clinical outcomes, metrics of importance, sales hygiene, and sharing of best practices.
    - Implement monthly skillset shadowing of liaisons with internal clinical and rehab team members in order to elevate product knowledge to the level in which liaisons speak about the center's features more in-depth and furthermore, leverage their benefits in ways that increase access to referral sources and convert patient referrals into admissions.
    - Leverage the current comradery between business development team members by developing peer group type, accountability buddy- mentorship groups with liaisons, AD, and AC to increase touch points and sharing of best practices on business development priorities.

Everest recommends organizing the center's business development resources around important referral source relationships within the center's service area. The necessary steps in effectuating this change, include first, defining the market and designating account priority, and then ensuring the appropriate personnel and strategies are deployed to maximize ROI. The quantity of referrals generated, volume of referral sources, and the number of business development representatives working admissions for , make it even more essential for the streamlining of strategy and efforts. Communication in referral generation, the intake function, and the admission event, is key to optimize the BD teams' productivity.

- Recommendation: Align Talent: clarify the workflow between external liaisons and internal admission team members by market/account designation to streamline business development processes, facilitate effective communication flow and improve quality of account management. Account-personnel alignment should entail the elements listed below:
    - Designation and streamlined ownership of referral platforms such as manual faxes, Navi Health, EPIC, Allscripts, etc.
    - PCC CRM utilization
    - Real-time communication flow of incoming referrals and pertinent information for approval/denial/conversion via platforms such as Tiger Text or using company email for email chains if email is verified as a secure network
    - Proactive management of patient experience and communication of patient movement (including discharging, AMA, readmissions, appointments, etc.)
    - Internal admission teams' provision of clinical outcomes and positive experiences to liaisons for increased referral generation.

- Recommendation: Review the clinical admissions screening protocol, admissions trends, and clinical denial trends with DON, liaisons and internal admissions team members to ensure clinical elements of referral generation and the intake process are understood and positioning the team for efficiency and effectiveness in their sales activity.

The unstructured environment is a disadvantage for the team, regardless of the positive team dynamic and their commitment to support one another. The first step at systemizing the workflow is to increase communication with the team and processes. Marshalling of appropriate resources through designation of accounts/personnel and standardizing the intake process in terms of referral capture, clinical review, financial review and response are tactics critical to SNF business development success. Due to the lack of process and standardization of systems, Everest believes the team is missing the opportunity to convert new referrals to admissions but overall, the center has great potential for success. To optimize the opportunity at hand; Everest recommends implementing more consistent onsite coaching to elevate the BD team's understanding of SNF business development strategy in terms of business performance management, and market mastery as further discussed in the upcoming sections of the report.

Business Performance Management:

A high-level understanding of the significance behind referral trends and conversation ratios were absent in conversations with liaisons and the internal admissions team. Although the internal team could provide an estimation of numbers and admissions trends, neither the liaisons nor internal admissions team could answer Everest's questions on strategic referral management. As a result, the Everest team recommends the immediate implementation of PCC trainings in terms of elevating business performance management and integrating continued coaching on the utilization of PCC data such as; census, referral, admissions, trends for business development planning.

- Recommendation: Implement Business Development specific PCC trainings and ensure they include the following:
    - Properly utilizing PCC CRM for sales hygiene and improved IDT workflow:
        - Streamline new admissions workflow by using waitlist feature for all new admissions.
        - Optimize PDPM rate capture by inputting new admissions and uploading clinical documentation within appropriate timeframe to support MDS in rate optimization.
    - Pulling Census Numbers (daily/weekly/monthly/yearly) with the "Quick ADT Report" to proactively create long-term and short-term business development plans, and effectively responding to real-time situations that require team to adjusting business development plan due to the organic nature of the business.
    - Utilizing the "Action Summary" for business development planning and real-time activity:

- Identify input/output and determining appropriate sales team follow up based on real-time admissions, readmissions, discharges, etc. I
- Identify and track trends for BD messaging such as readmissions, discharge to community, etc.
- Identify internal trends and perform root cause analysis with corresponding team member for census growth optimization such as readmission trending, or proactive discharge management with social services to prevent "Pop-Up Discharges" in which a patient leaves the center prior to achieving care goals due to reasons such as being homesick or dissatisfied.

- Using "To/From Admit/Discharge Report" to assess market share shifts, understand reasoning and proactively develop growth plans or relationship repair plans.

It is crucial for the team to know how to pull the information quickly and to use PCC as a tool for workflow efficiency rather than compliance. The business development team lacked structure and as a result is operating in a reactive state of catching referrals rather than driving new business. The Everest team's intentions behind the questions regarding census trends, referral volume, and admissions numbers, were to understand the level of thought and deliberate planning involved in the team's highly active workflow. Everest believes the elevated understanding of PCC as a tool, and the coaching of the numbers and trends as elements directing sales activity will allow the business development team to take action in a more productive way. Data review is a crucial part of sales hygiene as it paints an evidence-based picture of your current position and helps guide the formation of strategies for goal achievement. A liaison's ability to process data in terms of needs identification is a valuable tactic that should guide business development activity.

Business development meetings are not occurring routinely with the team. It is important to note that every department head spoke on the importance of census growth and their commitment to it. However, they were unable to articulate what was being done to drive it or what should be used as a center differentiator in order to increase market share. Everest recommends the implementation of weekly business development meetings with the center's NHA, DON, Clinical Liaison, Director of Rehab, and Director of Social Services in attendance. The interdisciplinary discussions will eliminate any ambiguity around the center's input-output and allow for the formation of incremental census growth commitments. Additionally, the meetings facilitate census culture and shared accountability for census and brand management. Although Everest agrees that the business development team should be the primary persons fostering productive business development activity, Everest believes that census growth is the responsibility of the entire team. It is important for liaisons to work closely with their teams to align their centers' strategies with the market's needs. The collaboration between the IDT allows for the optimization of the center's intellectual capital and results in the elevation of service call messaging, and identification of new prospects or accounts. The sharing of internal successes such as outcomes, metrics, testimonials, and leveraging of industry connections are vital to the liaisons service call success as sales messaging is dependent on the provision of value and competitive differentiation amongst the center's SNF competitors. Business

development meetings are effective in driving this level of strategy and collaboration as they provide the team a designated space each week to discuss proactive ways to position for productive relationships with key referral sources in the market and allow the team to identify ways to leverage those relationships for referral generation and admissions conversion each week.

Market Differentiation:

The team's potential for market share capture is momentous. The provided market analysis will help the center identify niche opportunities to focus on within accounts and guide the liaisons service call messaging for advancements in same day referral generation and overall establishment of a strategic partnership.

Everest's market analysis and conversations with the team identified an opportunity for the center to brand an elevated customer experience and concierge like admissions service as a competitive differentiator between other SNFs in the market. Conversations with the liaisons an internal admissions team revealed that the centers current customer service performance are not at the desired standard. Due to the market saturation and high volume of referrals that all skilled nursing facilities within the market are working to process; Everest recommends that team develops a customer service strategy to leverage customer service tactics from the point of referral generation. Customer service tactics can include calling the family and patient at point of referral generation and talking them through their care requirements and SNF need, helping them understand their benefits, providing a virtual tour, or pre-admissions meeting with the center DON, Medical Director, Director of Rehab etc. The increased touch points will improve the likelihood of the referral converting to an admission but in addition to earning the business the concierge like service will generate positive outcomes, and testimonials to take back to the referral sources for continued business. To the appropriate extent Everest recommends modeling a customer service platform similar to a hospitality industry. This recommendation optimizes the team's talent and creates a different experience that will be desired by patients seeking post-acute care. Additionally, the tactic can be leveraged as a way liaisons can help the hospital decrease LOS and facilitate effective care transitions more quickly despite the liaisons restricted access to hospitals and patients. The customer service advantages should expand beyond point of admission and should include the internal admissions team relaying positive outcomes about the patients to the liaisons for post admission follow up with the referring case manager.

Aside from branding customer experience as the experience, Everest recommends leveraging the market insight report to guide the strategic formation and execution of business development plans that will grow the center's premium payer patient population. The center's clinical strengths and ability to care for patients at high acuity levels should be branded as a Medical Service Strategy. It is recommended for the liaisons to engage in reoccurring clinical shadowing and trainings that allow for their return demonstration of the team's clinical capabilities and furthermore leverage the acuity for market share growth. A continued focus on providing high quality care, improving customer satisfaction, maintain regulatory compliance will increase the center's viability of participating in care networks and other value-based payer models. Everest recommends increasing regional clinical support to build a bridge program establishing core clinical competencies, to then advanced clinical services and ultimately result in specialty clinical programing and niche optimization. The liaisons ability to effectively integrate the features and benefits of the team's aptitude and ability to care for high acuity population should be leveraged to positively position the center versus their competitors.

Additionally, partnering with agencies such as the local Department of Social Services presents a new community based direct admit referral flow and an avenue to improve the center's reputation. The center can participate in events that provide education to local seniors on facility programs and services through DSS resources, collaborate on Medicaid eligibility/application process, or even position the center as a place for respite referrals in patient transitions from home to long-term care in SNFs. Senior Centers are also a community resource that can be partnered with to increase the center's positive awareness and build trust with the population serves. Focusing on community organizations for productive relationships will be pertinent for establishing credibility with the community at large and professional accounts.

COVID Strategy: Creation of a High Touch Model with Decreased Hospital Access

The COVID-19 pandemic has changed the landscape for business development and has decreased liaison's direct access to referral sources and patients due to on-site restrictions. Below are Everest's recommendations of tactics to increase referral source and patient access.

- Adopt standard for Zoom sales calls with CM and key stakeholders within top 3 referral sources
- Implement real-time Zoom Virtual Tours/Care Transition Meetings for all premium payer
- Telephonic review of all new admissions w/ the discharging Case Manager
- Attempt to contact assigned Case Manager tied to each referral
- Tap into Navi health resources: telehealth, clinicians
- Understand CMS COVID guidance and optimize applicable waivers-including reduction or waiving pre-service expectations and expediting prior auth requirements in order to more quickly work through DC planning to transition safely efficiently and effectively-

save hours of time and resources and ensured that more beds were available in acute setting for COVID-19 pts

- Design a Home Health Agency strategy-fostering relationships with providers in the home-based care models for direct admit upon change of condition
- Identify and contact MD specialist and PCP assigned to each referral and utilize history understanding for PDPM assessment tied to care planning
- Requesting onsite assessment for all heavy care referrals
- Attend or (Recommend if not happening) Virtual PAC Participation in PPN/Network/Hospital/Payer Meetings
- Weekly/biweekly COVID reviews with key stakeholders to identify how can help manage LOS and care transitions
    - Sister facilities – Facilities within
    - Professional Accounts that include but are not limited to; leading health systems-hospitals/payer/medical groups-physicians
    - Community Accounts that include but are not limited to; HHAs, ALFs, ILFs, Memory Cares, Senior Living Centers, Chamber of Commerce, etc.