Key 2022 Health Care Trends, the Current State of Skilled Nursing/Long-Term Care and Using Data to Gain Clarity

During this session, we will review key 2022 health care trends and advance the discussion to the current trends within the skilled nursing/long-term care industry in particular. We will demonstrate how industry-driven data-focused insights can provide skilled nursing/long-term care organizations clarity into their landscape, and inform their strategic operational and financial actions in pursuit of a financially viable future.

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Here is a transcription of this session:

Stephen Taylor:

Good afternoon, or good morning, to everyone out there. Welcome back to Part 2 of our two-part series on Healthcare Trends Using Data. Quick housekeeping item, the information that we'll be sharing here is general in nature. If you have specific questions, please reach out to your CLA Advisor. Also, this will be a pretty dynamic conversation that we'll be having here over the course of an hour or so. I'm sure there'll be a lot of questions. We will absolutely do our best to answer all your questions. Please submit questions during the course of this discussion, and we will follow up with as many of those we can towards the end of the discussion here. And if we don't get to any of your specific questions, we will certainly follow up on those as well. I am Stephen Taylor, Principal of CLA. I'm joined for this conversation by my colleagues, Deb Emerson, and Seth Wilson. So Deb, I'm going to go ahead and transition over to you to cover our agenda and get things rolling here.

Deb Emerson:

Great. Thank you, Stephen. I appreciate it. So what we want to talk today, as we talked about in Part 1 of the series, we really want to highlight some of those healthcare trends that we're seeing in skilled nursing and how you can utilize data, and insights from that data, to really look at your organization and provide clarity and information that you can use for strategic, operational, and financial areas. So we really want to make sure that we're digging into the details as it relates to senior living. So as Stephen said, make sure you're putting questions in the chat, and we'd be happy to answer those as we go through the presentation today.

So if you'll remember, and if you participated in Part 1 of our Healthcare Trends Webinar, we left you with some of these questions. And so we looked at areas and talked about what was happening in the healthcare landscape. We know that healthcare was already a challenging industry to be in before COVID happened, and once COVID happened and we're dealing with the pandemic, it really only increased the complexity of the world that we operate in. And we know that the long term care industry continues to struggle with things like occupancy, workforce challenges, government scrutiny, not only

over the handling of the pandemic, but we're hearing a lot of information and scrutiny around related parties, and some of those organizational structures that we see within the industry.

We were fortunate when the CMS Final Rule came out for the Medicare payment updates for fiscal year '23, that there was a little relief in that Final Rule that came out... CMS, and the Proposed Rule, had proposed issuing a parody adjustment for PDPM of 4.6%. That was actually going to result in a payment reduction for the industry going into fiscal year '23. When they came out with the Final Rule, they actually spread that parody adjustment over two years. So a little reprieve in that area, but it gives all of us an opportunity to start looking forward and figuring out how we're going to adapt to those parody adjustments and some of the other regulatory scrutinies that we're seeing.

So, as you recall from these questions on our previous webinar, if you look at all of these questions, most of them have one word in common. And that's opportunities. So when we look at your organization and as you're looking at the ability to identify those opportunities, what are some action items that you can take related to those opportunities and how are you going to execute on those action items? And that's what we want to talk through today is really how do you focus on the action items and the execution of that information based off the data that's available.

So we talked about the focus on fundamentals. So when we're looking at this industry and we're looking at the data, we really focus on those opportunities in four different areas. We look at occupancy, and not just from the number of folks that are in your facility and in your bed, but really from a strategic marketing perspective. So if you're struggling with occupancy, how does that relate to your referral sources? Are there things that you need to do differently related to that? Then we look at revenue optimization. That might be a matter of looking at your clinical information, might be looking at your payer mix, different areas that we look at, and we'll get into some of the details of the data around that.

Staffing obviously is a huge thing that we're focusing on, as we look at the skilled nursing industry, and the long term care industry. Workforce challenges continue to hinder our ability to move forward and to be successful as we try to navigate some of these challenging times. And then of course, expense efficiency, right? So we've all focused on those in the past. We've all done analysis of where we're spending money, but have you really looked at where you're spending money compared to your peer group? And that's one of the things that we want to talk about today, is how do you look at the expense side and look at that in relation to your peer group.

So when we talk about opportunity and we think about that definition of opportunity, we're not only looking at opportunity from a financial perspective. So we're looking at it, again, from a market share perspective. We're looking at where are you spending dollars. And it's not just about looking at your facility, but looking at how do you compare to your peer group, looking at the market, looking at the state top performers, and what does all of that look like and looking at areas such as the clinical opportunity and looking at how do you provide support around retention and recruitment of your staff.

So really trying to figure out what are those opportunities that are going to drive your organization to be successful and to move in the direction that you want your organization to move. Not everybody is the same, not everyone is going to operate the same, and going after the same market. So you need to look at all of the information in total and figure out what are those opportunities for you. So I'm going to turn it over to Stephen for just a couple slides to talk about the data that we use in identifying those opportunities and the peer groups that we compare organizations to.

Stephen Taylor:

All right. Thanks Deb. So yeah, talking about the data. So we gathered data from a lot of different publicly available sources. So Medicare Cost Report data, Care Compare Five-Star Quality data, Medicare Claims Data, TBJ Data, combine that with a lot of algorithms to create over a billion data points. The

power of being able to look at all of those areas data points and put them together into something that actually drives some insight, is through the socialization of those data points. So it's the triangulating of those data points and those fact patterns based off of a specific facility and the attributes of that facility, and then comparing that to what's going on in their local market and their direct peer groups. That's really the power of it, because just looking at that data in isolation, you're in essence limited, in our opinion, over the insights that you can really gather there. So that socialization and triangulating those data points is extremely important, because then effectively that's what creates those insights. And then those insights ultimately are what drive the decisions and that effectively creates actionable data.

So let's talk about how we would actually look at our peer groups in defining different peer groups. So we have the ability to take any SNF in the country, that file, that it's a Medicare-certified SNF, and we can compare that SNF or group of SNFs to three different peer groups, in essence. So the first peer group would be the local market peer group. And what we would define that is, we take the hospital or the hospitals that SNF receives the referrals from. And then we look at that hospital or that group of hospitals and say, all right, well, what other SNFs are they sending patients to from an episodic standpoint? Where else are... what are SNFs of those hospitals utilizing in addition to your skilled nursing facility? And that comprises that direct market because, like it or not, those are your direct peers because the hospitals are sharing referrals with those organizations as well.

So in this instance, there's 10 facilities. So there's 10 facilities that your SNF gets discharges from a hospital. Those hospitals send their referrals also to 10 other facilities. So that's your direct peer group. The second one is the CBSA. So that's a core based statistical area. And then the third one is the state top performers. And that's really an empirical definition that we have based off of a trend, with quality, positive operating margins, and we look at that over a time period. We say, okay, within that state, here are the top performers. In this instance, there's 16 top performers in that state. So we would take the one school nursing facility that's selected and then we'd have those three different peer groups. And that really gets into some of that triangulation that I was speaking to where you can say, all right, well how does a certain factor compare for our facility to that direct peer group, to the CBSA and to the top performers in the state?

Is that an area of opportunity for us, and how we would size that is where you see those dollar values up at the top. So keep in mind, those are in thousands. And how I would look at those dollar values is that, let's take a look at the market opportunities. There's 10 facilities there. So you see that and you say $783,000. What that is comprised of is, if you took a specific attribute that was a top performing attribute for a particular facility and added up all those top performing attributes, and if you were performing to the top of all those 10 facilities, and those various different components, the total opportunity would be $783,000. I think the important thing to think about there is really three things. One being, where is the financial opportunity? Is that financial opportunity actionable. So in this discussion, we'll be looking at things like occupancy, skilled mix, cost of labor. So are those areas that look as an opportunity for you, and then are those in areas that you can actually take action in? Is it an actionable area?

And then two, if it is actionable, then what's a reasonable size that opportunity, maybe that particular area, look at something like occupancy, or skilled mix, or cost of labor. And you say, okay, that looks like an opportunity for us, but how much of that opportunity is really realistic for you to capture? So globally, I would say that you really need to look at this in terms of where is there an opportunity, is it actionable, and really just using this as a barometer. That's that third component. So using those dollar values is really a barometer to gauge you of where there might be some opportunity. So Deb, I'm going to turn it back over to you to get into the discussion of some of those opportunities and starting with really the revenue discussion.

Deb Emerson:

Great, thanks Stephen. So when we go back to the four fundamentals that I talked about just a few minutes ago, and talking about those opportunities, I really want to focus on the market share, that kind of strategic looking at your referral sources, and the revenue opportunities together, because they really do play hand in hand in what your mix looks like at your facility, what your occupancy looks like, and where you're getting your referral sources from. And so when you think about that, one of the things that we really start out looking at, is your occupancy at your facility. So when you look at our information, back to the peer groups that Stephen was discussing, when we look at occupancy, the blue column is our selected facility. So we've created an organization for purposes of this presentation, and they're currently at 73% occupancy. So when we look at the market, the CBSA and the top performers, you can see that they're... the market's about the same, but then we start seeing that CBSA and those top performers having a higher occupancy.

So we know that it's a challenging market. And then that plays into who are we going after, especially when your market's pretty similar from an occupancy perspective, is there opportunity there to get more market share? We also look at the Medicare Fee-for-Service mix and for our facility, they only have 4% Medicare Fee-for-Service, and this will come into play in some of the other discussions that we look at from a revenue perspective. So when we look at this, why is the Medicare Fee-for-Service mix at only 4%? Do you happen to be in a market that's heavily Medicare Advantage, there's a heavy penetration of Medicare Advantage, and maybe you're taking on more of those advantage residents in your facility. Maybe you're a high Medicaid Utilization facility. All of that's going to play into some of those decisions you're going to make from an occupancy perspective and a revenue optimization perspective.

So we also look at that occupancy trend. So seeing where you're at, at a point in time, so back to that 73%, but we also know for this facility that occupancy was higher pre COVID, before the pandemic started, and we can see where it dropped down. And we can start to see that trend back up as we got into 2022, and that kind of recovery, whether or not we're truly in a recovery yet, I think still, depending on the cases, can be in question. But we want to know where are you going to level out from that occupancy perspective? Is there the ability to get back up to that 84, almost 85%? And if you can get back up to it, how long is it going to take you to get back up to that? And how does that measure into some of the decisions that you make on payer mix and staffing, that will cover in a minute?

So when we talk about the revenue and that occupancy payer mix, what we're really focused on then from a strategic marketing, is where did those referrals come from? So we have the ability to look at a particular hospital as a referring source and say, where in your market is that hospital sending patients? Where are they discharging patients to? So what other peer groups or other nursing facilities is that hospital sending patients to? So when we look at this, we can see that our selected facility is getting about 130 unique patients from that hospital on an annual basis. But the Medicare dollars that we're getting paid for those 130 individuals, is lower than the next competitors' SNF one, who's actually getting about the same, just a fewer patients than we are, but their dollars are higher.

So why is that? Are you looking at a particular diagnosis code? Do they tend to be more high rehab... back to the slide where we looked at your Medicare Fee-for-Service mix, that was very low. That would lead us to believe that you're more of a Medicaid heavy facility. And so you may be getting lower acuity residents coming out of the hospital, and that's why your Medicare payments may be lower. They may be transitioning off Medicare and on to Medicaid. But it begs the question to look at, if you are looking for the same acuity level resident from that hospital, then why are you getting more, but your payments are less? So then you start looking at the revenue and the pieces of the revenue and what is it about that revenue that maybe you have the ability to change or to maybe directly move upwards based

off documentation? So when I look at revenue optimization, we look at areas such as the contribution margin, and we look at the different components of the contribution margin.

So for our selected facility, you can see that our nursing labor is higher than either the market or the CBSA. So we're seeing about the same amount of Medicare patients. We're seeing fewer Medicare Fee-for-Service. We're getting less Medicare dollars, but our nursing labor cost is higher. Why is that? Are we using agency? Is that how we're being able to manage that? Really trying to focus on what is it that's driving these cost up and lowering the contribution margin. So digging into the various components to really be able to isolate and identify what is it that's driving the margin. I talked earlier about the PDP and Parity Adjustment. So factoring that into what's going to be happening in fiscal year '23, starting in October. So what are we going to see for changes in that contribution margin when Medicare payments start to go down? How can you adjust some of those components?

So looking at the nursing labor and being able to manage some of those costs, is it a therapy issue, is it another ancillary issue, and really kind of digging in and making sure that you are looking at your contracts for therapy appropriately? I know a lot of organizations when we transitioned to PDPM, spent time looking at their therapy contracts, so no longer focused on what they're paying per minute, but looking at the outcomes and the interdisciplinary play of therapy with your clinical team. And how is that now impacting that contribution margin at your facility. So really diving into the details.

But we also want to look at it in a more granular way, right? So we want to focus on being able to capture all of the quality of care that you're providing to your residents. Even if you're a low Medicare Utilized facility, as we identified for this particular organization, we're seeing a lot of the Medicaid programs that utilize a case-mix system that have been on the Rug System are now starting to transition into PDPM. Typically, they're using the nursing component, maybe nursing in the non therapy ancillary piece, but it's really important that you understand, and that you're capturing all of the quality services that you're providing to those residents.

So we have the ability to look at all that claims data and break it into each of the PDPM components. And we looked at the speech component for an example for this presentation, because it's the easiest to really identify where there's potentially a missed opportunity. So when we look at the A Component, under the Speech PDPM case-mix grouping, that means you're not capturing a swallowing disorder and you're not capturing any mechanically altered diet. So I look at this and our facility is the dark blue line, and we're comparing them to the state and national average. They're significantly higher in that A Component. It's the lowest paying component of the speech portion. And our question would be, why is it so much higher from the state and national average? Is there the ability to go in and look at how your interdisciplinary team is capturing those mechanically altered diets or a swallowing disorder, or are you leaving that up to the dietician to be able to document that?

So we go in and help you identify where there might be a potential for your clinical staff to not do things differently from the care they're providing, but making sure that they're capturing in the documentation, the actual care that they're providing. So we can look at this for all of the different PDPM case-mix groups, and it gives you an idea of what you might be missing from a documentation standpoint, but it also highlights for you, areas that might be a potential audit risk from a surveyor to come in. If you are really high on some of your nursing components around isolation, that might be an audit trigger.

So we really want to be able to identify those so that you can get the revenue that you're supposed to get, but also make sure that you're not setting yourself up for an audit in the future. So as we talk about those two components, kind of the marketing and the occupancy piece, and then the revenue optimization piece, we can't do either one of those, if we don't have staffing to support what's

going on at our organization. So I want to turn it over to Seth, who's going to walk us through the workforce piece of those four fundamentals.

Seth Wilson:

Excellent. All right. So jumping into workforce here, last month, I made a comment that staffing requires a great deal of analysis, collaboration, number crunching, to understand the operational and financial implications. There are so many things... I mean, direct care staffing is just the most critical function at your facility, that there's a lot to think about, a lot to look at. So we're going to dive in and look at some of those metrics that can be helpful when you're trying to make these decisions related to direct care staffing. So there are a number of metrics we're going to look at, but two key components that we'll start with here are, units of production, or the hours, and then the respective hourly rates. So we're going to start here with the hours and I'm going to paint a little hypothetical. You can close your eyes and imagine with me here, because this is maybe something, depending on your role, that you've done, or you've been in a conversation like this.

Imagine that you're looking at the financial statements for your facility and you notice it's not achieving its financial budget. Let's say it's short, approximately $300,000. So you're meeting with members across the organization, and all departments of the leadership team and such trying to ask, is there an opportunity here to do something different? Can we reduce hours in this area? And so you're approaching that conversation with the direct care clinical operational team here, can we reduce direct care nursing hours, particularly in contract labor? So you're entering the room, getting ready to join that meeting. And as you enter, before you even say anything, you hear the clinical and operational team discussing how there's not enough staff to achieve your target patient outcomes and patient experience goals.

So what do you do? So that's where we dig into the data. We really want to be able to understand what's happening. What are the facts and circumstances, the outcome? How does it all come together? I want the team to see as much information as possible to help us understand. And an important part of that as we've talked about here, is benchmarking against peers and competitors. So what we see here on this slide for workforce, is a stacked column chart. So visual, that's comparing the paid hours per patient day from the Medicare Cost Report with benchmarks, for facilities in the local market, the broader market, that core based statistical area, and overall rating of three stars or greater, and then top performers in the state. So those facilities that they're doing well in terms of their bottom line, and they're also maintaining that overall rating three or higher.

So if we compare with each of those across the board here, it's not difficult to see that our facility is reporting much higher paid hours than each of those other groups. And the difference here, if you look at it by category, appears to be a combination of LPNs in nurse administration, because you can see the LPNs are one versus 0.7, 0.8. The nursing administration is 0.6, versus the others are so small you don't even have a data label popping up. You'd have to do a cover over there. So those are the ones where it's bigger. And so if we perform some basic math here, calculating the difference of paid hours per patient day for each of those category, multiplying by the respective average rates per hour, multiplying by the annual census, it seems that... I mean, that could explain a $300,000 difference that we're trying to solve for. I mean, it's $360,000 if you compare with the local market.

And then there would be an even greater difference when comparing with the broader market or top performers, whether or not you want to do that, but all depends, right? I mean, your local market says a lot. That's certainly a meaningful benchmark. But I do just want to mention that if you look at the estimated opportunity for the CBSA and the top performers here, you'll notice that they're both $382,000. And the reason for why those are the same, even though the difference in hours is different,

will be more clear in a few slides here as we dive a bit deeper, but the short answer is that there's an acknowledgement that your facility's current staffing levels are thoughtful and intentional, and you're not just trying to staff like anyone else or a benchmark. There is something special about you and your strategy and what you're trying to do.

So let's look at the hours per resident day trend here. Rather than looking at the average hours per resident day over the course of an entire fiscal year, which is what we were just doing, it may be helpful to look at the hours trended over time. Let's see how much variation this is here. Is it really volatile? Are we being consistent with our practices and behavior and our ability to get nursing staff in and how are we adjusting for occupancy and such or census? So displayed on the left is a stacked column chart showing the national median hours per resident day, going back from the beginning of 2020 through the first quarter of 2022. So that's the national data.

And then to the right is the same visual for our facility. And beyond comparing total paid hours, what's interesting is to look at the gap between the total hours and the expected hours, which is referred to as EXP Total on the legend, that dot to the right. It's that bright line. It's bright green line going across the visual and that's representing what CMS expects the hours per resident day to be based on the MDS Data for that quarter.

So couple takeaways for me here. One, if you look at the expected hours, they're fairly consistent, both nationally, and for the facility. So to me, it's suggesting there's fairly minimal change in the resident case-mix. It's not going... it is moving, but it's not moving dramatically. And then the reported hours are fairly consistent, suggesting that our facility has some desired level of staffing and has not made any significant changes to it for at least the past couple years. I mean, you're hovering within a 0.5 or, plus or minus 0.5 from 6. You're really hovering around that six fairly consistently. It's not like you're going down to five, for example. So we'll have to do more to understand why the hours are so high, but before we dive a bit more into the hours, I do want to touch on the financial implications here, because again, this kind of all plays together.

So let's look at the average hourly rates. We saw how high the hours are compared to the benchmarks. How about the cost side? Well, the cost side is driven by rate per hour, which is affected not only by our employed rates, but also by contract labor utilization. So recruiting and retaining, we understand continues to be difficult. We talked about that last time. So more facilities are having to utilize agency and those that have been using it are using it more. At this particular facility, contract labor utilization is 18%. That's three times the benchmark we see here of 6%. That's a big deal. The difference in employed nursing rates and contract labor rates is approximately 50%, which is shown on the right. On the top right visual, you can see that the average staff, eight hourly wage, is approximately $20, and the contract labor hourly rate is approximately 30. So 50% difference on 18% of the direct care nursing hours. That's just looking at it from a financial perspective. That's not even considering all of the other operational implications of integrating agency.

So there are a couple things to consider for reducing this reliance on contract labor. One, if determined that the six plus paid hours per day we saw is too high, maybe we haven't made that determination, but if it is, then when we go to reduce the total hours, that can be directly to the contract labor bucket, which is the higher rate per hour, that we're incurring, to be able to provide this care to our residents and patients. Another thing here to consider is that, how competitive the rates per hour are. If we look at the facility's rate per hour here for CNAs, it's about $20, which is about $4 below the benchmark we see here of $23.

So I mean, one reaction is, well, no wonder the contract labor utilization is so much higher. I mean, they can go to the facility down the street and make four bucks more, 20% plus more. That's probably where a lot of the folks would be going. So it may be worth considering increasing the

employed hourly rates by 10 to 20%. And then maybe you can reduce that contract labor utilization from 18% down to 15% or 10%. And so it might be... in there, there's a whole bunch of ways you could do it, and there might be a break. Even there might be a way to have a bit of a net positive impact. Maybe the financial impact is a little bit of a net negative, but it positions you better for the future in what you're trying to do. All sorts of considerations.

Deb Emerson:

Seth, before you move on away from the contracted labor, can you explain where the contract labor information comes from? Is that from the cost reports or from the PBJ data?

Seth Wilson:

So what I am presenting on the screen right now is coming from S3-Part-5 of the Medicare Cost Report. However, that information is also available in the PBJ Data. So when we want to get more granular and see it on a monthly basis then, or quarterly basis, then we look to PBJ.

Deb Emerson:

Great, thank you.

Seth Wilson:

All right. So continuing this thought here about the intersection of hours and rates and what it means for financial impact, we understand that quality of care is important and maybe we should consider how our hours per day relate to the cut points used by the CMS Staffing Rating, because that's one system we have for measuring quality, or can be an indicator for quality. We know that staffing is a critical component of the rating system, and facilities with three or four star staffing rating, tend to have a higher overall rating, than those with maybe a two star staffing rating, for example. So let's look at the financial implications as we shift across these different cut points. So the staffing rating has historically looked at two case-mix adjusted hours per resident day measures, and that's case-mix adjusted hours for total nursing and case-mix adjusted for RNs.

The new rating system has expanded the tiers for each of those measures from quintiles to deciles, which is illustrated here. So this used to be a five by five matrix. Now it's a 10 by 10. I'm not showing the lowest decile here. So it's a nine by nine, but we're looking at deciles instead of quintiles, and across the top are column headers representing each decile for case-mix adjusted total nursing hours per resident day. Across the left side are roll labels representing each decile for case-mix adjusted RN hours per resident day. Then, really what I want to focus on is shown here in the bottom right, near the bottom right, at the intersection of 4.429 total hours. So that's in your column, 4.429, and then in the row near the bottom left for 0.992 RN hours. The intersection of those two, there's a cell here shaded dark blue with a value of $111,058.

So let's talk about that dark shaded cell. That represents our facility's position in this 10 by 10 matrix... nine by nine. And it's in the 80th to 90th percentile for both of those measures. The $111,058 represents an estimated savings, if our facility were to reduce the total case-mix adjusted and our end case-mix adjusted hours from what they are currently, based on this PBJ data we're using here, which is... the most current is from first quarter 2022. If we look at what that is compared to the cut points for this particular cell, and we multiply by the respective hourly rates, then we get that $111,000. So remaining in this cell, if we just did that, if we just got to the cut points for this cell, remained in this cell, then that has no impact on our staffing points, no impact on the staffing rating. From a CMS quality perspective, nothing has happened. We've just adjusted down to the bottom of the cell that we're in.

And this $111,000 is telling us there's cushion. We have... we're a decent amount above what the floor is for the cell that we're in.

The cells surrounding that dark blue one, are those where the facility may consider moving up or down one decile on either of the two measures. So let's consider leaving RN staffing alone, but reducing the total hours from the 80th to 90th decile, to the 70th plus decile. So that has a floor of 4.105 instead of 4.429. If the staffing were reduced to that floor, if we got all the way down to the 4.105, then there could be more than $300,000 of annual savings. The value displayed here is $381,613. And that $300,000 range, that happens to be the shortfall in our annual budget.

That's why we were going into this meeting to talk about... could we find that? So this is the conversation to have, is can we staff at 4.1 case-mix adjusted hours instead of 4.4? That's not an easy question to answer, but this is helping us understand, this would be the financial impact if we could do that. And maybe we can't get all the way there, but maybe we can figure out instead of 4.429 plus maybe we are at 4.3 or 4.2, somewhere in the middle, and that could help with some of what we're trying to do to balance our budget. So I want to link this back to the very first slide. The opportunity on that first slide, remember, was capped at $382,000 for the broader market that CBSA and also the top performers... and this right here, this is the reason why. Because that $382,000 is within one decile of the current staffing level.

So it would be easy for us to show potential savings of more than $1 million. I mean, you can see lots of large dollar amounts in these gray cells further away from the dark blue, right? It's like yeah, we'll just... if we go to the bottom 50th percentile, we can save a ton of money. However, again, we acknowledge that there's facility level strategic positioning, how you want to operate, so many factors that come into play there, that when we're showing you that opportunity value, we're saying, this is not a significant or material leap from what you're doing today and what you may think about doing what may make sense. And also understanding that to make changes in staffing levels can take a lot of time, take months to a year to kind make that transition or shift toward something different than what your team is used to doing.

Another thing here to note is that the paid hours that we saw earlier were six plus. But these hours here that we're looking at are four plus. So big part of that is these are case-mix adjusted hours. So they've been adjusted for case-mix, based on data from the MDS. So this allows the cut points to be fair for all facilities, with varying types of patients and residents, because it doesn't matter if you have the sickest patients that needed the most care, or the lightest caseload, easiest case-mix requiring the least resources rather, doesn't matter which type of facility you may be. These are universal cut points. And so you have... that's the purpose of that case-mix adjustment here.

So let's look now at the CMS star ratings. Before adjusting staffing and dropping a decile, it's important to understand the rating under the existing circumstances. Where are we today and what do the opportunities or risks look like? So this visual illustrates the point value for each of the six staffing measures for our facility, as well as a market benchmark. So the first two measures are the case-mix adjusted total and RN staffing hours per resident day, that we were looking at on the matrix on the prior slide. Each decile for those measures is worth 10 points for a max of 100 points each. So the max 100 points is represented here by that green dash up at the top, aligned with the 100 value on the Y axis.

The third measure, which is the third and final hours per resident day measure is specific to weekend hours. Notice here that the green dash is positioned at the 50 point value on the Y axis. This is still being scored. The points are still assigned based on deciles, but in this case, for this measure, the point value per decile is five points instead of 10 points. So five times eight here is what's getting them to the 40 points.

There are also two nursing turnover measures, each worth, a max of 50 points. So these are also deciles at 5 points of decile. And then the final measure is administrator turnover, which is based on number of departures, rather than percentage, because you have your one administrator and the max points here is 30 points. So little bit different scoring system for that one. But in terms of staffing, our facility meets or exceeds the benchmark for all six measures. So it's worth noting how well our facility is performing in terms of nurse turnover, especially. Perhaps direct care staff enjoy working at our facility more than others. Is that something that could be leveraged to reduce the contract labor issue that we observed a couple slides ago? That's something to explore here.

That said I'd like to focus on the staffing rating points and the ratings at the bottom. If we add up the points for all six of those measures, we have 330 points and that's resulting in a staffing rating of five. That five-star staffing rating is providing us a bonus, so that instead of an overall rating of one, our overall rating is two. So right now for our facility, that's a big deal. If we were not having a staffing rating of five, if we were below 320 staffing points, then our staffing rating would be four. We wouldn't have that bonus. We'd be an overall one-star facility. This is really important to consider because we don't want to lose that bonus and become a one-star facility. Our cushion is only 10 points. That means assuming everything else remains constant, we can only decline in a measure worth 10 points or two measures worth five points. So there could be a fair amount of risk here and even some questions around why staffing is so high, but the survey and our quality ratings are so low.

That's another indicator here, is how is staffing being correlated with those other quality components. For the sake of time, let's assume that the low rating is driven by a really poor survey result from three years ago. That's part of the weighted average. It's about to be replaced by a better, more current survey. And so we're not as concerned about that, because we know we're going to end up with the two or three star survey score going forward and we're not going to be in this tough position here.

So setting the risk aside, if we look at the six measures, we can adjust the total nursing down one decile from 80th to 90th percentile, to the 70th to 80th percentile. You can see that selected at the top center drop down there for total nurse staffing. All the other ones here I've left current, to say, I'm not going to consider changing any of those right now, but just if we've reduced the total nurse by that one decile, then we see on the right hand side, the total points drop from the 330 to the 320, which now is at that floor. But because it's still at the floor, it hasn't dropped below it. We are still five-star staffing rating. And again, in the bottom center there, you see that little card displaying the financial impact, which is that $382,000 of potential savings that we saw on the matrix earlier. All right. So with that, I am going to turn it over to Stephen to talk about a couple other cost centers that we can look at.

Stephen Taylor:

Thank you, Seth. I really appreciate you running through that. I think there's so much going on right now, obviously with workforce, staffing, agency utilization, that having a lot of different ways you can slice and dice that information, I think, just puts a lot of our folks in our industry, more in the driver's seat, instead of a little bit of a reactionary environment, especially linking that up with some of the comments that Deb was making earlier around occupancy, for example. I know a lot of organizations really rolling into 2022 was, okay, we are at the low point of occupancy. We got to recapture that occupancy. We got to get that one percentage point per month. And at least a lot of the clients that I work with and folks that we chat with around the industry, I think a lot of them are doing that unknowingly at a lot of agency utilization.

Well then all of a sudden when agency rates go through the roof, you step back and you think, okay, well, is that occupancy recapture kind of worth the agency spend that we're seeing, especially

when you consider things like your skilled mix or your overall payer mix. So I love the way that you have some helpful slides that it really went through. Okay, well, how can you step back and assess how have you been staffing or utilizing agency over the course of the prior couple months? And is that a behavior you're actively changing or something that maybe you should be? So I think that was really insightful. So thank you, Seth. I do want to leave some time for Q&A at the end here. So I'm going to go through these next two slides rather brief, just so we have plenty of time for Q&A.

So another area to think about is in therapy... your therapy overall expense per patient day. I think the two things I think about there is, as Deb mentioned, reviewing your therapy contracts, considering that and how they're aligned with the acuity and the utilization of therapy services with your resident and patient population, and then the overall efficiency of those services with your resident and patient population. And then another one is around direct expenses. So that kind of gets to the expense efficiency that Deb mentioned earlier. And I know as an industry, we're very cost conscious and we are aware of where our spend is taking place for the most part. But just as an example, we threw this one up here for dietary spend. So it's being able to look at that spend on a PPD basis, and then compare it to those different peer groups to identify, okay, is there an area of opportunity, but then even deeper than that, where is that area of opportunity?

So for example, on dietary expense... so our total cost per patient day, was higher than the other peer groups. Well, why is that? Our paid hours per patient day, slightly above. Our salaries per patient day certainly was not necessarily an area that stood out, but what does stand out is our other costs or supplies cost. So what is our contract with our supply vendor for dietary supplies, raw food, for example? What is our raw food spend compared to our market? The thing that I think is great about looking at an example like this is, it allows you to identify where in that local market, is there a potential opportunity, but then to also step back and think, all right, if you look at that average salary per hour... so this is being, this number right here, is coming from the most recent cost report information, Medicare Cost Report information, which is for a lot of folks is a December 2021 number, but you can step back and think, okay, I know the comparative of my local market weren't reducing wages, and I bet the CBSA was increasing wages as well. So where was our wage spot in the fall or back in 2021? Have we moved in alignment with our market?

So it allows you to look at areas and identify, where might there be a for sure opportunity such as the raw food cost, but then also where might there be an opportunity if we say, increased wages a bit, or in this case kept wages where they are, but then looked at more of how we're utilizing those wages. And could we maybe get a little bit more efficient with the leverage on our staffing and our dietary department? So I'm going to go ahead and open it up for some Q&A and me, I'll start off with one question that I get a lot when we talk with folks and I'd love to pull Seth and Deb in, to answer this question as well, but a lot of the data and the information that we obviously have here, like I said earlier, comes from PDJ data, nursing home Compare, Medicare Claims Data. And then the most recently available Medicare Cost Report data.

And a lot of folks sometimes say, well, how is that Medicare Cost Report data relevant? And maybe it's eight months old. We are in a dynamic market. And a lot of the times I genuinely believe that it allows us a strategic advantage of, one, having a wide swath of data that we can pull from. So any facility coast to coast is instantly in the data set. So you get a lot of peers that you can compare yourself to. And then two, it allows you to be in a position where you are identifying areas of potential opportunity and in those areas of potential opportunity, obviously there's dynamics that happen in an eight month period of time. But for example, if your average hourly wage rate for a salaried CNA was 20% below your local market peer group, and 15% below your CBSA, and your current agency utilization is through the roof, you kind of connect those data points and you say, well, obviously yeah, that maybe

our exact salary per hour rate might be eight months old, but all indicators are that we were paying below market by all these different metrics eight months ago.

So unless we've done 15, 20% pay rate increases, it's likely to assume that you're paying below market currently. And obviously that's more of okay, that's an area that we're identifying potential opportunity. Now let's take that conversation to Level-C, or pull in your CFO or your COO, and get into a conversation of what have we done in this example to adjust wage rates going forward. So it's really a barometer of saying, all right, how do we compare to our local market? Was this an area of opportunity or not? Has anything changed in the past couple months that would drastically impact that? Seth, Deb, any thoughts on that, when you hear folks that might question if six months old, seven months old cost reports are a valid data set?

Deb Emerson:

Yeah. So Stephen, I think it's a great question. And it's one that we've gotten numerous times as we try to pull this data together. I think two things that happen. One is, it is actually much current. So we're only looking at 6, 8, 9 months lag from that cost report data where it used to be more like 18 months. So it's somewhat more current than it was in the past. So I think that's helpful. But it's important to take that 2021 cost report data and look at it as part of the total picture. So we have the ability through the PBJ data and the claims data that we're getting that is more current information. So we're looking at 2022 information and being able to tie that more current information to the financial information that you're getting off the cost reports, whether it's rates per hour, your rates per PPD, if you're looking at an expense area and say, okay, here's where we were at on a PPD basis in '21. I know that our occupancy is now going up or we're having to use more agency and we're paying more for it now than we were in '21, and how is that impacting us, and being able to tie it all together and make strategic decisions.

The other thing that I've worked with providers in using this data is, taking that information and being able to set up benchmarks for them on a monthly basis. So, you know what your data looked like in 2021, how are you going to make improvements in 2022 and beyond? So if your dietary PPD was $40 and your goal is to get it down to $38 a day, can you start to measure that internally and use that as a benchmark? So you're not always going to have that market comparison, but if you have a goal in mind, then when you complete the 2022 cost report, and we can do this analysis based off that data, you can see where you've made improvements in your market. Seth, I don't know if you have additional thoughts. Stephen, sorry.

Seth Wilson:

No, I don't. Both you and Stephen nailed it. That was great.

Stephen Taylor:

I think the key thing that stands out when you're going through that is, in my opinion, the most important thing about any exercise. When you look at operational performance improvement, financial improvement, it takes socialization and it takes an outside perspective sometimes. It takes individuals that are there that know their organization's data better than anybody, but then when you merge those two together and it's the socialization of those ideas and identify, okay, maybe five out of six things are not an area of opportunity, within that sixth one is a huge area of opportunity. But I think the best way to identify those a lot of times is through that socialization. I feel like that was a common theme in what you were describing there, is identifying something, but then working collectively with an organization in pursuing it and maybe more clearly defining it.

Deb Emerson:

And one other thing I would like to add just to the conversation, because we've been very focused in looking at the data, looking at that PPD, looking at those opportunities, but the ability to use this data, to your point, Stephen, with being able to socialize, it is also being able to socialize it with your directors or managers across your organization. So with my example of dietary... so it's not just a front office, accounting staff saying, we need to manage dietary better. You can then show this data to your dietary manager and say, we need to focus. We need to make some changes. We need to manage this better. How can we do that? And then you have the ability to hold that dietary manager accountable for making changes and kind of giving them that opportunity to own their department. And you can really do that across the entire organization, whether it's therapy, nursing, your housekeeping, laundry, you then get input from everyone on how things could be, how operationally you can do things differently. That's going to be to the betterment of the residents that you're serving as well as financially for the organization.

Stephen Taylor:

Not to put you on the spot, Deb. But one question that's come through the chat that I also get a lot is, what are some high level things you could do to identify if your PDPM rates are a potential area of opportunity for you?

Deb Emerson:

So that example that I showed on the speech/language pathology benchmarking, looking at that benchmarking and seeing how your facility compared to the state and national average is, particularly the state. How do you compare in each of those case-mix groups and really looking at, is there an outlier? So if your A Component of the speech is 50% higher than the state average, is there a missed opportunity there? And so maybe you want to do an MDS review or have an audit of your documentation to make sure that you're capturing the services that are being provided. That's really the biggest thing... to be able to highlight those opportunities is to be able to compare your facility to a market or a state and see how you compare in each of those PDPM categories.

Stephen Taylor:

Excellent. And then I'm not sure if we'll have time to answer this next question, but Seth, you covered the area on workforce. Folks that might look up the workforce utilization... you know what, actually, we only have 30 seconds. I think we might not have time to get into a workforce question, but we'll make sure that we follow up with everyone on the questions that were submitted. I'm going to go ahead and fast forward here to our contact information. There's Deb, Seth, and my contact information for everyone. Please, of course, feel free to reach out. Overall at CLA, we believe that this current environment poses a great threat to a number of skilled nursing facilities, but it also creates a lot of opportunities for others. And we also believe that strong quality and financial indicators are becoming more and more critical, which is really the core part of what we discussed here today.

And we understand we've been... I think that it's important to understand where we've been and then also where we're going. So trending that data and making those connections between those data points is extremely important. So, CLA... we're here to help. As I mentioned, our contact information is there. We have an extensive team. We're a large organization, which gives us an opportunity to have a lot of resources at our disposal, really focused on knowing our clients, knowing our markets. And honestly we are here to help you and support you. So I appreciate everybody's time this afternoon and hope we talk soon and appreciate everybody's time and attention. And thank you.

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