USF | Muma Case Review
A publication of the Muma College of Business | University of South Florida

Volume 7 Number 8 1 DECEMBER 2022

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SIGNATURE HEALTHCARE – WHERE DID THE CAREGIVERS GO?[1]

We can no longer admit more patients due to the nursing shortage. What do we do since we still want to grow the company?

Christine Busby stood in her office and stared at a blank whiteboard. With a marker in hand, she asked herself, "Where do I start?". Mrs. Busby had a key role to play in changing how the skilled nursing facility (SNF) industry did business. There were several complicated factors, multiple rules, and regulations to navigate, little money, and no time to execute this colossal change. To add to the stress, she worked for a company known for its innovation and was often a *first mover*. All eyes were on Mrs. Busby as she figured out how to save an industry.

Mrs. Busby, MS CCC-SLP, MBA, had been the V.P. of clinical services for 11 years and the V.P. of care management for the previous three years at Signature HealthCARE, LLC (SHC). She had been a driving force and change leader inside SHC and was now asked to oversee care redesign, a restructuring of the nursing side of the business. Patients continued to need skilled nursing facilities services, and its relevance would only increase as baby-boomers aged. The issue that confronted SNFs was the lack of nursing to provide care. The severity of the nursing staff shortage was a new phenomenon compounded by the COVID-19 pandemic, wage disparity, and workload; all while hospitals were being mandated to staff a certain number of nurses based on the facility's census. In other words, fewer nurses meant fewer patients and less revenue.

Mrs. Busby needed to figure out how to retain the nurses they already had and attract new ones without significant salary increases during a nationwide nursing shortage. Should Signature close facilities to decrease the overall bed count? Could they successfully lobby the state to allow paraprofessionals to perform some nursing duties? Were there technological resources that could be brought in to improve efficiency and working conditions? Mrs. Busby faced huge hurdles, and time was of the essence.

Editor: T. Grandon Gill

Nursing Industry and Senior Care Industry

The growing number of aging adults, in conjunction with chronic diseases and sedentary lifestyles, contributed to the growth of the nursing care industry. Advancements in medical technology also played a role in diagnosing and treating the elderly population, thus contributing to the continued increase in this industry. To the skilled nursing industry, this was the perfect storm. Some of the roles found working in a nursing home are as follows:

Certified Nurse Assistant (CNA) /Medical Technician (Med Tech)

Certified Nurse Assistants (CNAs) are primarily responsible for helping patients with activities of daily living (ADLs), such as bathing, grooming, toileting, eating, and moving. On the other hand, Medical Technicians (Med Tech), also referred to as nursing aides or nursing assistants, work closely with staff and nurses to provide patient care.

Licensed Practical Nurse (LPN)

A licensed Practical Nurse (LPN) may perform the same duties as CNAs but offers more extensive nursing care. LPNs also supervise CNAs. The role requires education in a state-approved program and passing the National Council Licensure Examination (NCLEX) through the National Council of State Boards of Nursing.

Registered Nurse (RN)

According to the American Association of Colleges of Nursing, nursing is the nation's largest healthcare profession, with more than 3.8 million registered nurses (RNs) nationwide (The American Association of Colleges of Nursing, n.d.). A nurse's responsibility may range from patient care to patient advocacy and includes administering medicine and treatment as prescribed by a doctor, tracking patient vitals, and maintaining patient records.

The nurse is responsible for the daily application of treatment and for monitoring the patient (some nurses can diagnose and prescribe treatments with an appropriate level of training). Nurses are typically with the patient from admission to discharge.

Registered Nurses (RNs) oversees both CNAs and LPNs. They provide the most in-depth level of nursing, with job duties that include performing diagnostic tests, analyzing results, determining treatment plans, and instructing patients on how to manage their illness. An R.N. must hold a minimum of an associate degree in nursing from a two-year program and pass the NCLEX exam, though employers increasingly require a four-year bachelor's degree. Many R.N.s opt to pursue additional certification in an area of specialty.

The Competitive Landscape

As outlined in Exhibit 1, there are many levels of senior care:

Skilled Nursing Facilities (SNF*)*–Skilled Nursing Facilities (SNF) provide a range of medical care services that support a patient's continued recovery from illness, management of chronic disease, or disability after a hospital stay. This high-quality, post-acute care is available at a much lower price than hospital stays. An SNF provides in-patient rehabilitation and medical treatment facilities with trained professionals available 24 hours a day, 7 days a week.

Hospice Care–Hospice Care can also be found within an SNF and provides end-of-life care for terminal individuals. Palliative care focuses on individuals with a serious illness regardless of age and can be

provided as the primary goal of care. A team of professionals, including physicians, nurse practitioners, home health providers, social workers, ministers, and family members, works together to provide compassionate care to a patient with six months or less to live.

Home Healthcare–Home Health Care provides a wide variety of health care services that can be administered at the patient's home. Home health care is designed to help patients get better, regain their independence, become self-sufficient, slow the decline of the disease, and/or maintain the current condition or level of function.

Assisted Living Facility–Assisted Living Facilities provide care for older adults who can no longer care for themselves but do not require the higher level of care a skilled nursing community offers. Assisted living communities encourage independent living but aid with activities of daily life. Although assisted living communities do not provide medical needs, they often partner with other healthcare professionals to help residents in need of medical services.

Continuing Care Retirement Community (CCRC)–A Continuing Care Retirement Community, referred to as a life plan community, includes independent living, assisted living settings, and a skilled nursing facility. Nurses and doctors are on staff to ensure the patients' health, safety, and well-being.

Size of the U.S. Nursing Care Market

The U.S. Skilled Nursing Care market size was projected to reach $460 billion, as shown in Exhibit 2, with a 6% compound annual growth rate (CAGR) from 2020 to 2025. This growth expectation came from several key factors. Although the projected growth in the industry seemed promising, an increase in one segment could be offset by a decrease in another. An example of key factors that affected the skilled nursing care industry census include:

- The rise in the geriatric population from the baby boomer generation is referred to as the "Silver Tsunami"
- Chronic diseases
- Technological advancements such as telemedicine
- Value-based purchasing –pay for performance program

Disruptors in the Industry

Conditions that disrupted the landscape of the industry:

- Covid-19 accelerated the evolution of consumer preferences and expectations. More patients requested private rooms and amenities for their safety and to make their accommodation feel more like home.
- Baby boomers expressed interest in maintaining their independence and chose to "age in place," which increased the desire for home-based care, senior living communities, and assisted living facilities.
- Patients moved to lower-cost settings (home healthcare).
- The nursing shortage affected the entire nursing care industry.

Signature HealthCARE

Signature HealthCARE's (SHC) culture was based on learning, spirituality, and innovation, which inspired excellence among their staff. It also empowered residents, stakeholders, and families to live with purpose

(Signature HealthCARE, n.d.). Yet, SHC was not immune to the nationwide nursing shortage that threatened their existence.

The shortage of nurses in the nursing home industry was a national issue, and what made matters worse was the federal action that required COVID-19 vaccinations for long-term care workers who served Medicare and Medicaid patients. This announcement had far-reaching consequences that would jeopardize SHC's ability to grow its business and would potentially devastate the nursing home industry.

Requiring vaccinations of nursing home workers was a commonsense idea since most fatalities during the first wave of the COVID-19 pandemic occurred in nursing homes and because the likelihood of contracting or spreading the virus in the healthcare facility would be reduced if all workers were vaccinated. The second wave of COVID-19 cases confirmed "a strong relationship" between the number of nursing home patients who contracted the virus and the number of vaccinated nursing home staff (The White House, 2021). Yet, the downside of the vaccine mandate was potentially devastating to the skilled nursing industry. The language of the legislation originally only mandated vaccines for nursing home workers and facilities. This gave underpaid and overworked nurses and paraprofessionals a reason to leave nursing homes in search of a more lucrative and less stressful work environment. Hospitals and other medical facilities not under the vaccine mandate could lure nurses and other skilled staff away from Signature, putting additional pressure on their ability to provide quality patient care and grow. But through effective lobbying, at all levels of government, this mandate was changed to include all healthcare facilities that accept federal payers. The change in regulatory language avoided worsening the nursing shortage in long-term care facilities and losing Medicare and Medicaid funding (Cunningham, 2021; Florida Health Care Association, 2021).

Another aspect of the regulations that made SHC's mission to "revolutionize the healthcare experience through an innovative culture of person-directed care" tenuous, was how the mandate itself affected medical workers who were hesitant to get vaccinated (Signature HealthCARE, n.d.; Cunningham, 2021). Although Mrs. Busby noted that nursing homes were "very heavily hit with COVID-19," a large group of SHC employees did not want to be vaccinated (Mauro, et al., personal communication, September 6, 2021). According to Mrs. Busby, 53% of unvaccinated workers would leave the nursing home industry if they were "forced" to get vaccinated (OnShift, 2021). Mrs. Busby went on to argue that SHC was "already in a crisis and that it could not afford to have that many stakeholders and employees leave" the company. Losing over half of the workforce would prohibit SHC from caring for existing patients. "This is our 'biggest' legislative issue" (Mauro, et al., personal communication, September 6, 2021). Mrs. Busby lamented the fact that a vaccine mandate was an avenue for SHC employees to go into other settings. It is "an exit door for our staff," exacerbating an already critical nursing shortage. Although the COVID-19 vaccine mandate appeared to be in the rearview mirror, it did not eliminate the nursing shortage. To reduce the stress brought on by overworked nurses and quell the exodus of skilled nursing home workers, SHC decided to focus its attention on expanding the definition of licensed professionals and paraprofessionals working in nursing homes to include nursing aides, patient care technicians, nurse techs, and other related health care occupations. Expanding the definition of licensed workers would increase the workforce and improve patient care while allowing nurses and others to work at the top of their licenses. Expanding the definition for certified workers would require state approval.

To create state legislation to broaden the definitions of licensed professionals and paraprofessionals working in nursing homes, there needed to be an advocate who was a member of the state's legislative body and a member of the committee that oversaw nursing home facilities. Fortunately, SHC was headquartered in a district with representatives at the state and federal levels who sat on such subcommittees. This issue was brought to their attention from the beginning of the crisis. SHC and other nursing home advocates spoke on why this legislative language was important and outlined the kind of

outcome they wanted. They created issue briefs for use in meetings with the Representatives and frequently met with members of their staff to educate them on the issues. Next, they contacted and met with subcommittee staff to share the need for broadening the definition of certified nursing home workers and requested a hearing on the issue with subcommittee staff with testimony from SHC and association presidents. A coalition made up of constituents and other stakeholders increased the likelihood that a hearing and legislative action would occur as they cited that a broadened definition of licensed/certified nursing home workers would benefit businesses and all citizens in their home districts.

Technology

"*The health sector is one of the sectors that is most exposed to technological evolution. It is being impacted by digitization which is revolutionizing the way healthcare is provided, from the interaction between patients and caregivers to governments and stakeholders."* (Melo & Araújo, 2020).

Society was preparing for the 4th Industrial Revolution. Skilled nursing facilities would need to increase their reliance on technology to decrease nurses' workloads. The first step in moving toward efficient quality care involved innovative mobile solutions. These technologies allowed staff to increase documentation accuracy and improve efficiency (Saunders & Vehvilainen-Julkunen, 2018). SNF's CMO Dr. Arif Nazir believed that an investment in technology was necessary to help with nurse frontline burn-out. Workflow technology could be used to erase redundancies. Tech investment and implementation were broken down by the "need of the hour" (Stulick, 2021).

Cost

Mrs. Busby's most significant roadblock to implementing technology to supplement the shortage of nurses was cost. Updating all SHC facilities' infrastructure, I.T. department, and educating staff on modern technology would come at a considerable cost, and the patient's needs broke down the investment and implementation by the hour.

Medical Wearables

Wearable technology could affect critical decision-making. Some believed that wearable technologies could improve the quality of patient care while reducing the cost of care, such as patient rehabilitation outside of hospitals (Wu & Lou, 2019). Wearable technologies enabled the continuous monitoring of human physical activities. The most common wearable devices in healthcare were designed to measure data for vital signs such as heart rate, blood pressure, and body temperature.

Nurse Rosie

Rosie was a company that provided long-term care solutions, devices, and supplies. SHC could use Rosie to empower caregivers with state-of-the-art devices, electronic healthcare record connectivity platforms, and supplies. Using Rosie, nurses could spend additional personal time with patients instead of spending their time checking vitals. This could also improve job satisfaction and potentially reduce the high turnover rate for R.N.s and CNAs.

BASE10 Software

BASE10 software was a platform used to manage modern disease control and provide organizations with solutions to quickly make decisions that would scale back disruptions. The platform provided employees with actual data directly to the nurses' phones. The benefits BASE10 can provide were:

- 13 million data points

- 14 million dollars in savings
- Infection control
- Precision Nutrition
- Precision Medication
- Access to patients' Electronic Medical Records (EMR)

What Did a Nursing Home Do? The Skilled Nursing Business Model

Skilled nursing homes (SNFs) work in the sub-acute healthcare market and are designed to care for two separate and distinct patient types. First, there was the long-term care model, and this population was referred to as "residents" since they lived in the facility as their home. This was the typical nursing home people think of. These residents were medically complex and required around-the-clock care. They needed frequent care from physicians, nurses, and therapists. These facilities provided physical, occupational, speech, and respiratory therapy. The level of care was such that returning home was not realistic.

The second type of patient an SNF cared for was the short-term rehab patient. This patient had a recent hospitalization but was now stable and no longer considered acute. This patient typically required extensive therapy care to return home as quickly as possible. The typical length of stay was between 11 and 21 days depending upon the patient's admitting diagnosis, prior level of function, and discharge plan. For example, someone who would be discharged, and home alone would need to function at a higher level than a person who had many helpers.

The SNF industry was highly regulated and competitive. Ninety-nine percent of an SNF's revenue stream came from third-party payers. Third-party payers were insurance companies that included standard commercial payers such as Blue Cross, Humana, United Health Care, and federal and state payers such as Medicare and Medicaid. This meant that SNFs themselves did not determine their reimbursement. The payer set it. Short-term rehab patients could be covered by either a commercial insurer or Medicare Part A. For example, assume a patient was admitted with a commercial payer, such as United Health Care, the SNF clinical team (physicians, nurses, and therapists) would be told what the patient's level is by the payer. That level would determine the reimbursement per day. A typical plan would have anywhere from one to four levels depending upon the patient's complexity. These levels determined how much therapy care would be provided and even what medications would be paid for.

Once the clinical team had an opportunity to assess the patient thoroughly, they coulc request a higher level, but the payer did not always grant this. Weekly updates would then be sent to the payers' case manager a minimum of once per week (usually twice) and they then would decide when to discharge patients and send them home. The clinical team could object or ask for an extension but this was typically denied. The pressure on the SNF was to rehab patients as quickly as possible to get them to a level where they would be safe at home as soon as possible. Medicare used a different reimbursement model, although it still generated a per-day fee. Medicare used a complex model called the Patient-Driven Payment Model or PDPM for short. An assessment would be completed by aggregating all the clinical team's information into one document (this document would take about 4-5 hours to complete). The information and patient data on that assessment would be graded and a score calculated. That score translated to a reimbursement number. Patients admitted with Medicare part A as their primary payer got more control as the patient and their clinical team received a full 100 days of coverage if required. However, the patient would incur a $145 daily co-pay starting on day 21.

Medicaid did not cover any short-term rehabilitation as it only covered those residents who called the SNF home. Medicaid also paid a "per-day" fee, but it was significantly less than the fee a rehab patient would generate. These per-day rates included all services provided by the SNF, for example, nursing care, therapy, medication, physician visits, and many labs.

SHC was a typical SNF because it had both types of patients in its facilities. They did not have an opportunity to set their rates and therefore could not compete in the industry on price. Like many healthcare providers, it they could only compete on service and patient outcomes. The only way to increase top-line revenue was to increase facility census or adjust the payer mix. Survival in the SNF industry boiled down to keeping census up and controlling costs.

The regulatory environment had significant impacts on the industry as well. Every year inspectors would spend 3-4 days in the facility to inspect every aspect of care and the physical plant. After exiting the facility, the SNF operator would receive a letter listing the deficiencies and associated fines from the state. The listed deficiencies needed to be corrected and then the inspectors would make a return visit to verify that the corrections were implemented and were effective. Inspectors often made off-cycle visits to follow up on any complaints they received. Some states, such as Florida, dictated staffing standards for nurses and certified nursing assistants. Specific ratios needed to be met or an SNF had to put themselves on an admissions moratorium. For example, the nurses and the certified nursing assistants (CNA) had to meet a minimum standard of 3.6 hours per patient day (PPD). To calculate this, you would add all nursing and CNA hours delivered over 24 hours and divide that by the number of patients in the building. If there were 300 hours of nursing care and 100 patients, the PPD would equal 3.0. The SNF industry in Florida was required to maintain a PPD of 3.6.

The SNF industry was compelled to serve many masters, the patient, the payer, referral sources, the regulator, and the inspector. Payers also had the right to inspect the medical chart at any time (up to seven years post-discharge) and determine if the treatments performed met all expectations and met medical necessities; answering the question, were the treatments given truly medically necessary? If they determined that care was not medically necessary, they would take back some or all the reimbursement received for that patient. However, the SNF was still out-of-pocket for all costs associated with caring for that patient.

Signature's core competency was taking care of patients. They did an excellent job getting rehab patients back on their feet and able to care for themselves. They had made considerable progress over the past few years, decreasing the overall amount of time it took to get a patient from admission to back home. But this too created a problem. The better the job you did, the more patients you needed to admit to keep census at reasonable levels. Finding referral sources involved a combination of relationships and sharing data. Signature's primary referral sources were hospitals, and they were looking for sub-acute partners that could accept almost all patients, get them home in short order and make sure they did not end up back in the hospital. Patients that ended up back in the hospital for any reason within 30 days of discharge from the SNF costed the hospital money.

Signature had made many tough decisions over the past 18 months and no longer had any low-hanging fruit expenses that could be cut. Overall staffing and management had been streamlined and everyone's workload had increased some. Therefore, the only way to stay alive or prosper further as a company was to grow the census. The problem was that to increase the census, we needed nurses to care for them. The ratio of nurses and CNAs to patients was tightly regulated and had to meet a PPD of 3.6 daily. If the SNF were to fall below that threshold two days in a row, it had to put itself on an admissions moratorium for

six days. That meant patients could only be discharged but not admitted resulting in a decrease in the overall census and further exacerbating the problem.

Decision Summary

Christine Busby and Signature needed to make critical decisions, the options to improve long-term viability were:

Become a Nursing Educator to Grow Business–SHC could enter a joint venture with an area nursing school. SHC could benefit from the financial gains associated with the partnership while securing a pipeline of nurses to work in the SHC facilities as presented in Exhibit 3 (U.S. Department of Labor, n.d.). The program would focus on geriatric education, the dementia disease process, its progression, and how to work with those patients. This type of focus was lacking in traditional nursing programs.

Traditional nursing programs tended to focus more on the acute patient and hospital-based environments. Having Signature involved in the education process allowed them to work with the curriculum and enjoy some of the profits created by the school. In turn, SHC could now offer tuition reimbursement for those graduating nurses that came to work for SHC. SHC could also offer extensive clinical experience throughout its facilities for student nurses.

The school should offer two distinct programs, new graduate LPN programs, and an LPN to R.N. bridge program. The new LPN program would help drive new aspiring nurses into the profession faster than a traditional R.N. program. This could be a powerful recruiting tool. The school could also offer LPN to R.N. bridge programs, and this could be a powerful recruiting and retention tool. Signature could offer tuition reimbursement in return for a work commitment for a certain number of years thereby decreasing turnover. In this scenario, current LPNs working for SHC could attain their R.N. education at little to no cost.

Cut costs to limit the loss–To rapidly cut costs, SHC could close some of its buildings by mapping geographic locations that could be consolidated. Consolidating locations would allow SHC to close one building and consolidate staff. There was an associated salary cost savings as well as only one administrator, director of nursing, director of therapy, social worker, and business office manager would now be required.

There were a few negative consequences to closing a facility that also needed to be considered. For example, there would be a loss of potential revenue. If Signature were able to fully staff its locations it could potentially fill all beds, but if a location was closed, those beds would no longer be available. They would also potentially lose the license for the beds in the closed location. In the SNF business, beds needed to be licensed by Medicare and Medicaid and there had to be a certificate of need. These were difficult to get and once they were given up it wouldn't neccessarily be possible to get them back. All decisions had both pros and cons and closing a facility certainly had compelling cons. However, the cost consolidation in the short term may have been worth it so SHC could live to fight another day.

Lobby to get a broader category of skilled nurses–Unify lobbying efforts across the nursing care industry to get their legislators to expand the number of licensed or certified job categories that were allowed to serve on a nursing home staff. State and national advocacy groups such as the Florida Health Care Associate (FHCA) and the American Health Care Association (AHCA) could assist with this initiative.

Increase efficiency of care through technology–Using innovative technology could help nurses be more efficient, remove some of the burdens, and help to eliminate burn-out. Technologies that could be used

included medical wearables, the Nurse Rosie platform, or even a more simplistic speak-to-text dictation system.

The wearables and Nurse Rosie system would require a significant hardware investment along with training and continued I.T. support to keep the systems running. However, they provided improved data collection and quicker responses to patient issues, and would eliminate some work for the nurses as they no longer needed to provide vital signs.

However, the verbal dictation capabilities were easier to deploy, required less training and I.T. support, and were considerably less expensive. This system would allow nurses and CNAs to simply dictate their notes, no typing required. This could be a quick win for Signature and their nursing staff who would quickly embrace the capability.

Long-term cost reduction by acquiring the land–Set a team in motion to re-engineer the real estate investment trust (REITS) at each facility. Rather than leasing the property for at least some locations, purchasing the building and land would provide substantial savings over time by reducing the year-over-year escalators built into the agreement. Additionally, the money invested in the building for maintenance and upgrades would now add to the value of the business, rather than to a facility that SHC does not own.

Standard business practice in the skilled nursing world typically entailed that the facility be run by a separate operating business entity (such as SHC) that did not own the actual brick and mortar building or the land it sat on. The building and land were owned by a real estate investment trust or REIT for short. A REIT leased the building to the operating company. The leases were generally expensive and had built-in year-over-year escalators, meaning the lease would go up a certain percentage each year. What's worse, the maintenance of the physical plant was the operator's responsibility and not the REIT's.

This business arrangement probably made sense in an era when SNFs needed an influx of capital and debt was expensive. However, the cost of the lease had exceeded the cost of a mortgage and now debt was cheap. Leasing had several drawbacks. Here were a few of the most significant:

1. Leases were triple net (NNN). This meant that the operator was responsible for the maintenance and improvements on the property which could be expensive (The JCH Senior Housing Investment Brokerage, 2015).
2. Operators were also responsible for all real estate taxes.
3. The license to operate resided with the REIT and not the operator.
4. When evaluating the value of a SNF business, the land and plant accounted for 70-80% of the value and the business entity itself only 20-30%.

Some of the advantages of leasing were as follows:

1. The operator did not have to come up with the cash for a down payment.
2. Less costly to grow your number of facilities.
3. Less liability.

Owning the land and plant could free up cash flow long-term that could be used to improve reimbursement of critical staff. Mortgage payments did not escalate year after year and eventually provided an asset that could be tapped for future cash flow. This may mean that Signature had to shrink in overall facility count, but this may be a viable option if the goal was profitability and not facility count.

Skilled nursing facilities generally sold on a "per bed" basis. Current prices hovered around $90,700 per bed. So, for a typical 120-bed facility, a sales price would be approximately $10.8 million. To put this in perspective, a typical monthly lease payment exceeded $100,000 but the payment on a

$10.8 million mortgage at a 6% interest rate equaled $65,000. This math was being used for demonstration purposes as a down payment would most certainly need to be made, further lowering the monthly cash requirements. Remember, the operator was already paying the taxes and maintenance costs so there was no additional expense.

All these options were potential solutions; however, they differed regarding feasibility, the effort required, cost, and timeframe. There was no single solution that could solve the nursing crisis. However, a combination of a few might be the best way to deal with this crisis long term.

Mrs. Busby knew that she needed to be prompt and make key decisions for SHC's survival, perhaps the industry's survival. A few things were abundantly clear; first, business as usual would no longer work. Second, the industry needed to be reimagined. The question was how would skilled nursing add value and meet the needs of the future patient? Third, there were no quick fixes.

We contend certain decisions would need to be made to keep Signature financially viable long enough to implement the longer-term solutions but there were no meaningful short-term decisions that would stem the tide and improve revenue. Without improved revenue and cash-flow, Signature would not be able to pay their clinical staff the amounts necessary to retain and recruit them.

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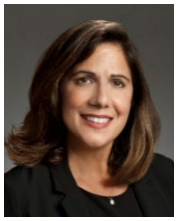
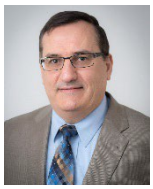
Biography



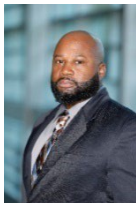
Paula M. Durspek- HR/EHS Business Partner/Ethics Officer, General Dynamics Ordnance and Tactical Systems. Paula M. Durspek's duties vary as an HR/EHS Business Partner with General Dynamics Ordnance and Tactical Systems, a position she has held for more than two years. Her responsibilities include managing and analyzing Affirmative Action Plans for the company's 26 locations. She also reviews and implements best practices for the Sarbanes Oxley (SOX) H.R. controls for the H.R. Department and all its locations. Previously, she served as a SOX compliance officer and executive assistant for Sonic Automotive. Durspek received a bachelor's degree in marketing from USF in 2001 and completed an internal investigation certificate program in 2020.

Archie Hill-Research Associate- RMC Research Corporation. Archie Hill, a research associate with RMC Research Corporation, manages and plans contracts for the Region 7 Comprehensive Center, including providing technical assistance and professional development to state personnel standards and assessment, school and instructional improvement, and effective practices in reading instruction. Prior to his current position, Hill served as an adjunct faculty member at George Mason University and Northern Virginia Community College. He also worked as a U.S. House of Representative intern and staffer. Hill earned a PHD in education from George Mason University, Virginia; a master's degree in applied sociology from Norfolk State University, Virginia; and a bachelor's degree in sociology from the University of Virginia.



George Makdisi currently serves as an associate professor of surgery at Albany Medical College. He is the surgical director of the Mechanical Circulatory Support and Surgical Treatment of Advance Heart Failure unit. Prior to that George worked as an attending surgeon in the division of Cardiothoracic Surgery & Transplantation at USF/TGH and in University of Kentucky. Makdisi earned a medical degree from the University of Damascus in Syria. He earned masters' degrees in oncology, public health and medical science and information technology from Université de la Méditerrané. He then moved to the United States for general surgery residency, completing a cardiothoracic surgery fellowship at the Mayo Clinic College of Medicine.

Richard Mauro-Regional Operations Officer, Signature Rehab. Richard Mauro is a regional operations officer at Signature Rehab where he balances clinical and business management skills in the rehabilitation and physical therapy field. He has hands-on experience overseeing efficient, cost-effective operations, including contract therapy services, outpatient services and in-home care. Mauro has a record of leading operational and marketing strategies that optimize program success, revenue growth, staff performance, survey/audit results and patient care. He is a vision-focused, entrepreneurial-minded leader with consistent performances surpassing admission, budget, and revenue projections, including achieving multimillion-dollar growth.



Jernard Woodard- Retired Military, U.S. Army- Jernard Woodard served in several leadership capacities in the U.S. Army before retiring in 2019. He is an astute military professional with 20 years of supervisory and logistics management experience, skills he used when he worked most recently with G.E. Aviation. He is well versed in warehouse logistical support and transportation needs and he is adept at gathering and translating complex customer requirements in viable action plans. Woodard received a bachelor's degree in business finance from Liberty University, Virginia, in 2016.

Exhibit 1: Senior Care Levels

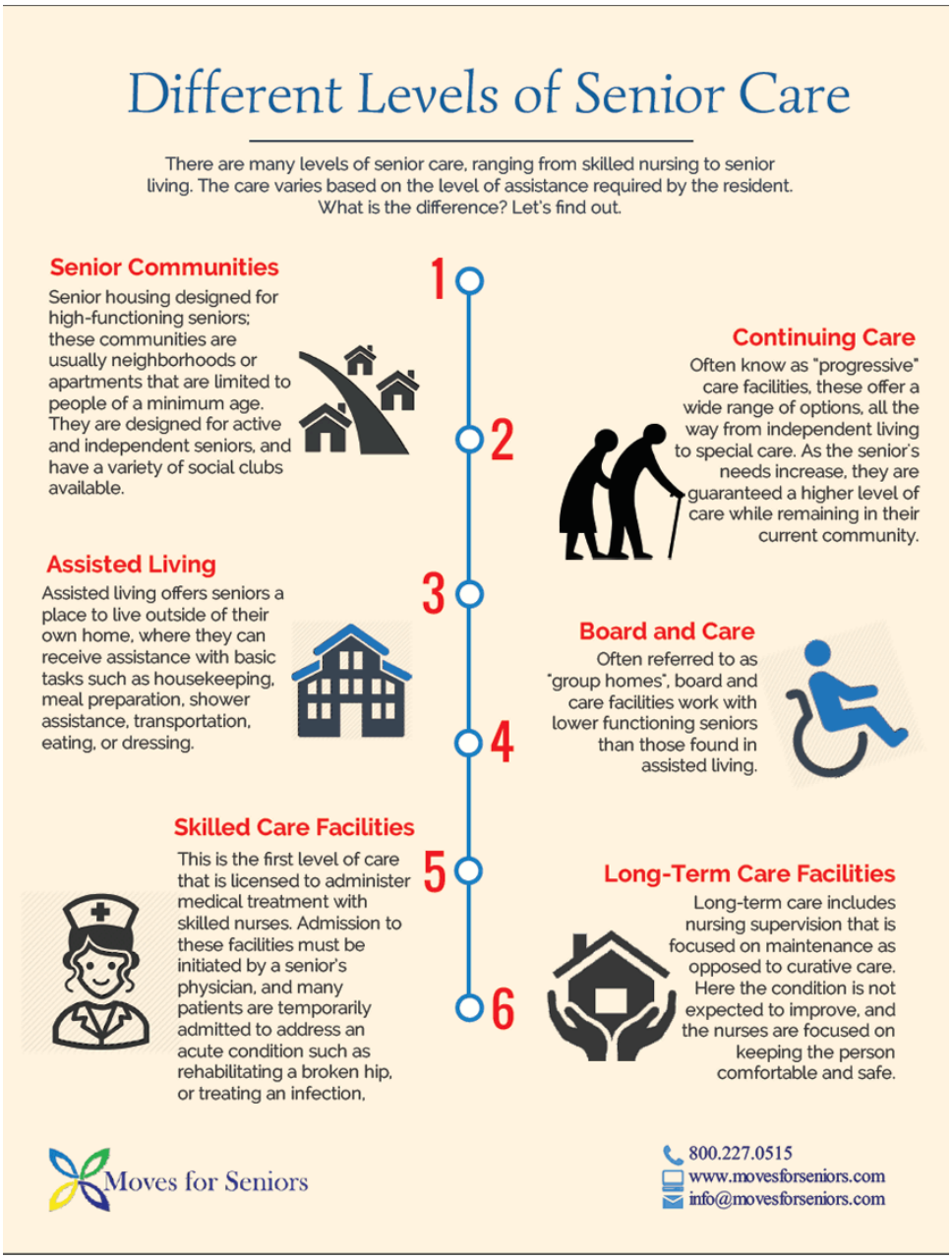


Exhibit 2: Map of Nursing Facility Shortages

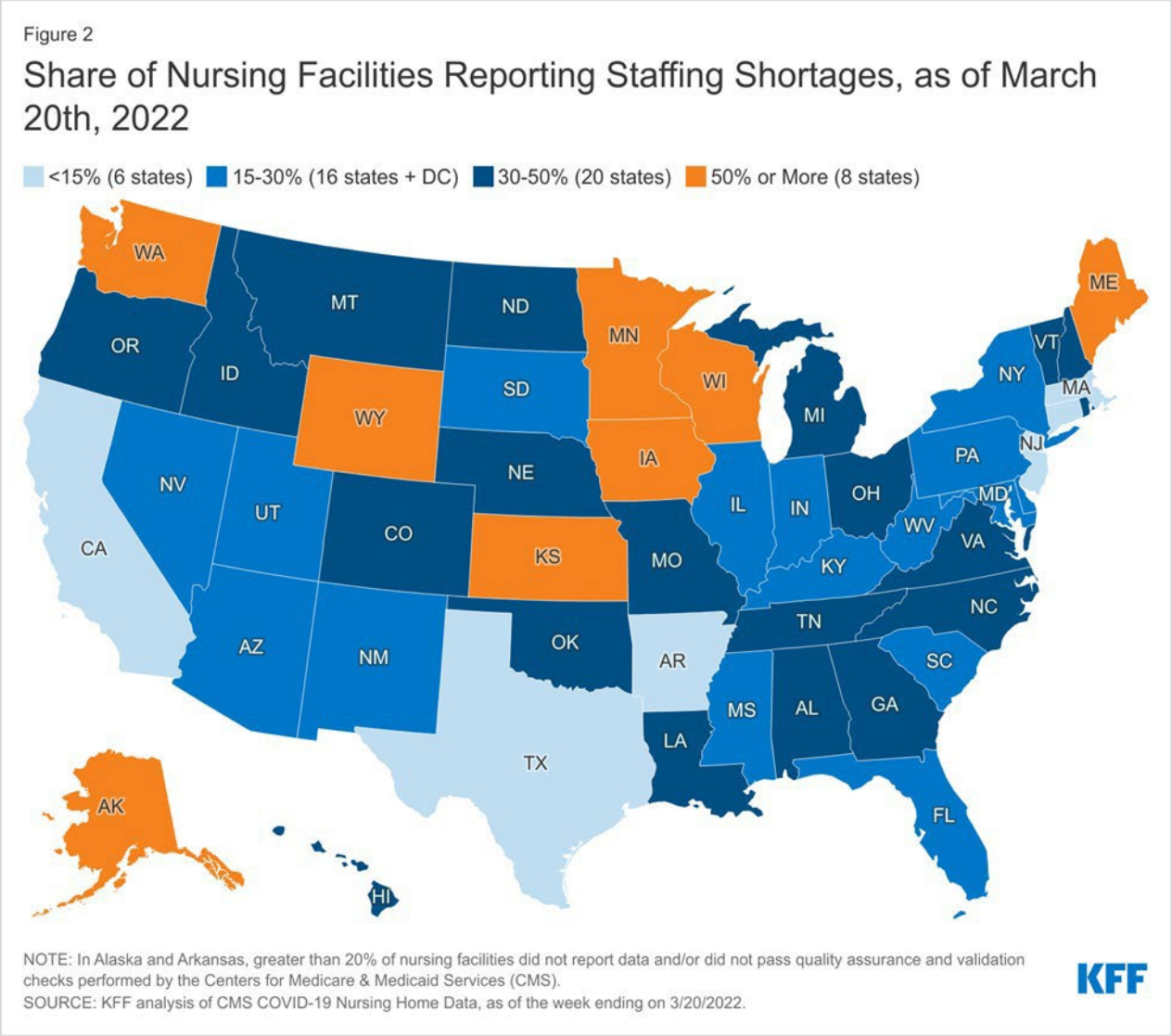


Exhibit 3: Nurse Salaries Across Employees

R.N. Salaries by employer			RN Largest employers	
Government	$84,490		Hospitals; state, local, and private	61%
Hospitals; state, local, and private	76,840		Ambulatory healthcare services	18
Ambulatory healthcare services	72,340		Nursing and residential care facilities	6
Nursing and residential care facilities	68,450		Government	5
Educational services; state, local, and private	64,630		Educational services; state, local, and private	3
LPN Average pay			LPN Largest employers	
Government	$51,700		Nursing and residential care facilities	38%
Nursing and residential care facilities	50,100		Hospitals; state, local, and private	14
Home healthcare services	49,430		Offices of physicians	13
Hospitals; state, local, and private	46,560		Home healthcare services	12
Offices of physicians	44,830		Government	7
Nursing Assistants Average pay			Nursing Assistants Largest employers	
Government	$37,240		Nursing care facilities (skilled nursing facilities)	37%
Hospitals; state, local, and private	32,160		Hospitals; state, local, and private	30
Nursing care facilities (skilled nursing facilities)	30,120		Continuing care retirement communities and as	11
Continuing care retirement communities and ass	30,020		Home healthcare services	6
Home healthcare services	29,210		Government	4